Semi-Annual Report to the

Joint Legislative Oversight Committee

on Mental Health, Developmental Disabilities and Substance Abuse Services

on

Mental Health, Developmental Disabilities and Substance Abuse Services

Statewide System Performance Report

SFY 2008-09: Fall Report

Session Law 2006-142

House Bill 2077

Section 2.(a)(c)

October 1, 2008

North Carolina Department of Health and Human Services

Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Executive Summary

Legislation in 2006 requires the Division of Mental Health, Developmental Disabilities and Substance Abuse Services to report to the Legislative Oversight Committee (LOC) every six months on progress made in seven statewide performance domains. This report is the fifth in a series of reports, with each report building upon previous reports. The following are highlights from each of the domains herein.

Highlights

Domain 1: Access to Services – (1) The number of persons enrolled by local management entities (LMEs) across the state has been declining in recent years in every age-disability group except adults with mental health disorders and adults with developmental disabilities. The decline represents both improvements in data management and increasing complexities of sharing substance abuse data with LMEs. (2) Almost all persons seeking emergent care are seen by a provider promptly after requesting services; over three-fourth of persons seeking urgent care are seen within 48 hours of requesting services; and approximately two-thirds of persons seeking routine care (non-urgent) are seen within seven calendar days.

Domain 2: Individualized Planning and Supports – (1) The majority of consumers with developmental disabilities report choosing their case manager, much like reports of consumers in other states. (2) The vast majority of consumers with mental health and substance abuse disorders report choosing their provider and the services they received. However, fewer adolescents report being involved in choosing their provider or services than other age groups.

Domain 3: Promotion of Best Practices – (1) The number of persons receiving evidence-based mental health services has been increasing over the past two fiscal years, while the number in evidence-based substance abuse services steadily climbed, but fell in the fourth quarter of SFY 2007-08. (2) Admissions to the state alcohol and drug treatment centers have increased considerably in recent years, while there has been a notable drop in admissions to state psychiatric hospitals in the past year. (3) Readmissions to state psychiatric hospitals have been lower for children than for adults.

Domain 4: Consumer-Friendly Outcomes – (1) While most North Carolina consumers with developmental disabilities report choosing where they live and work, a much larger percentage report choosing the staff who assist them at home and work. (2) Mental health and substance abuse consumers continue to show meaningful improvements in various aspects of their lives after three months of service.

Domain 5: Quality Management Systems – (1) The Division has implemented the Frequency & Extent of Monitoring Tool, used to determine how often a particular provider agency needs to be monitored and how general/thorough that review should be. (2) LMEs are focusing improvement efforts on increasing crisis services, service access, and data quality.

Domain 6: System Efficiency and Effectiveness – (1) LMEs' timely and accurate submission of information to the Division has improved by 16 percentage points over the last two years. (2) Ten LMEs have received single stream funding as of June 30, 2008. However, only three have reported the expected volume of services for the fiscal year as "shadow claims."[1]

[1] Information on units of services provided, associated costs, and consumers served is collected utilizing the IPRS and Medicaid systems. LMEs that receive single-stream funding for State-funded services or that participate in certain Medicaid Waivers do not use the claims system to receive payment for services provided. In order to capture information about the services provided, the state has instructed these LMEs to submit "shadow claims" for services provided (claims for which they do not expect to be paid). The claims processing system fiscally denies these claims (showing amount paid as $0), but captures relevant information about services provided. This allows the state to monitor publicly funded services funded by Medicaid and State funds.

Domain 7: Prevention and Early Intervention – In 2005, North Carolina received a Strategic Prevention Framework State Incentive Grant (SPF SIG) from the federal Substance Abuse and Mental Health Services Administration (SAMHSA). In the second phase of this project, 18 local counties identified local factors that contribute to their high rates of alcohol-related traffic crashes. In the third phase, these communities are receiving technical assistance and training to address these problems in a locally-relevant manner.

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Legislative Background

Session Law 2006-142 Section 2.(a)(c) revised the NC General Statute (G.S.) 122C-102(a) to read:

> "The Department shall develop and implement a State Plan for Mental Health, Developmental Disabilities and Substance Abuse Services. The purpose of the State Plan is to provide a strategic template regarding how State and local resources shall be organized and used to provide services. The State Plan shall be issued every three years beginning July 1, 2007. It shall identify specific goals to be achieved by the Department, area authorities, and area programs over a three-year period of time and benchmarks for determining whether progress is being made toward those goals. It shall also identify data that will be used to measure progress toward the specified goals…."

In addition, NC G.S. 122C-102(c) was revised to read:

> "The State Plan shall also include a mechanism for measuring the State's progress towards increased performance on the following matters: access to services, consumer friendly outcomes, individualized planning and supports, promotion of best practices, quality management systems, system efficiency and effectiveness, and prevention and early intervention. Beginning October 1, 2006, and every six months thereafter, the Secretary shall report to the General Assembly and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services, on the State's progress in these performance areas."

Quality Management Activities since the Spring 2008 Report

Since the April 2008 report, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (the Division) has completed the first of the three years of the State Strategic Plan 2007-2010 as required by the General Assembly. Progress made on topics of particular interest to stakeholders, such as crisis services, provider monitoring, customer services and the CAP-MR/DD waivers, will be reported in a series of quarterly updates over the next two years. See the Division's website at http://www.ncdhhs.gov/mhddsas/.

In addition to implementing the Strategic Plan, the Division has accomplished a number of other important activities that relate to continued refinement of a data-driven, improvement-focused quality management system. Major activities include:

- **Renewal of the annual Performance Contract between the Department of Health and Human Services and each local management entity (LME).** The SFY 2008-09 contract includes higher expectations on the critical performance indicators as a reflection of improvements over the past year in the state averages on those indicators. LME performance on these indicators, as well as other important measures, is published quarterly in the *Community Systems Progress Reports* on the Division website at http://www.ncdhhs.gov/mhddsas/index.htm.

- **Development of comprehensive tools for evaluating LMEs' completion of contracted functions.** This set of function-specific tools has been developed with the help of contractors funded through Session Law 2006-66 (Senate Bill 1741). The tools are currently being piloted across the state, in preparation for full implementation in January 2009 by the Division.

- **Development of standardized tools and protocols for LMEs' monitoring of provider agencies.** The tools for evaluating the quality of provider services were developed in collaboration with LME and provider representatives and are currently being piloted across the state, in preparation for full implementation in January 2009.

- **Inclusion of information about community MH/DD/SAS provider agencies in the NCcareLINK system.** This information and referral system, managed by the Department of Health and Human Services' Office of Citizen Services, provides web-based information to North Carolina residents on the location of a variety of services within their counties. Inclusion of LMEs' and MH/DD/SAS providers' information is an important step in improving state residents' access to services. Access to NCcareLINK is available at http://www.nccarelink.gov/ .

- **Streamlining of NC-TOPPS (North Carolina Treatment Outcomes and Program Performance System).** This online system allows providers, LMEs and the Division to track service needs and outcomes for consumers of mental health and substance abuse services. With assistance from LMEs, providers, and consumers, the Division has simplified the questions and processes for gathering this information. The Division is currently working to improve local partners' timely access to information on the consumers they serve.

- **Publication of quarterly reports on admissions to local emergency departments by individuals with mental health, substance abuse, and/or developmental disability diagnoses.** These reports, based on data collected by the Division of Public Health, are provided to LMEs to help them determine service needs and plan for crisis services.

- **Publication of a Community Service Needs Assessment Workbook.** This workbook, along with technical assistance, has been provided to LMEs and counties participating in the Strategic Prevention Framework State Incentive Grant to reduce the incidence of alcohol-related vehicle crashes. The workbook and technical assistance outlines steps to guide communities' processes for identifying populations and strategies to target in the project.

Measuring Statewide System Performance

The domains of performance written into legislation reflect the goals of the President's New Freedom Initiative and national consensus on goals that all states should be working toward, specifically to provide support for individuals with disabilities to be able to live productive and personally fulfilling lives in communities of their choice. The Division has chosen measures that can be used to evaluate the implementation of system reform efforts and the impact on system performance and consumers' lives. The measures relate to:

- The strategic objectives of the *State Strategic Plan 2007-2010*.
- SAMHSA National Outcome Measures (NOMS) (See Appendix A for details).
- Areas of quality recommended in the CMS Quality Framework (See Appendix B for details).

Where applicable, the Division is also aligning measures of statewide performance with local performance indicators published in the quarterly *Community Systems Progress Reports*, so that each LME can evaluate its own progress in relation to the state as a whole.

For each performance area, the following sections include:

- A description of the domain.
- A statement of its relevance to system reform efforts and importance in a high-quality system.
- One or more measures of performance for that domain, each of which includes:
    - A description of the indicator(s) used for the measure.
    - The most current data available for the measure.
    - Division expectations about future trends and plans for addressing problem areas.

Appendices at the end of this report provide information on the data sources for the information included in each domain.

Domain 1: Access to Services

Access to Services refers to the process of entering the service system. This domain measures the system's effectiveness in providing easy and quick access to services for individuals with mental health, developmental disabilities and substance abuse disabilities who require help. Timely access is essential for helping people get care during times of their greatest vulnerability and/or openness to assistance. It is the first step in engaging people in care long enough to improve or restore personal control over their lives, to prevent future crises and to minimize the impact of disabilities on their lives. Both the SAMHSA National Outcome Measures and CMS Quality Framework, as well as the Division's *Community System Progress Reports*, include measures of consumers' access to services.

Measure 1.1: Persons Receiving Community Services

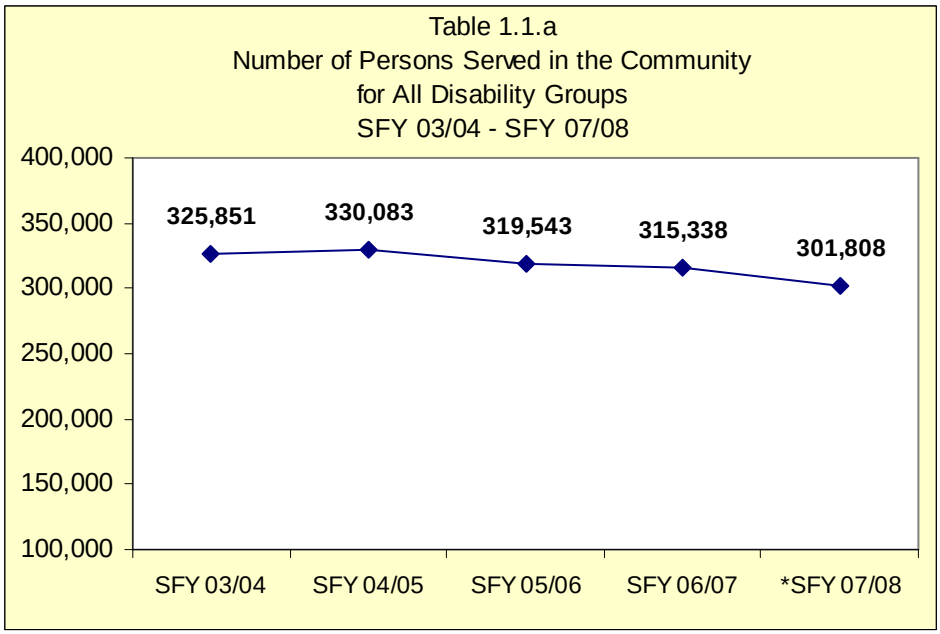
The Division is committed to serving individuals with mental health, developmental disabilities, and substance abuse needs in their communities rather than in institutional settings whenever possible. Tracking the number of persons that the LMEs serve in communities provides a barometer of progress on that goal.

Measure 1.1 contains information on the number of persons that the state's mental health, developmental disabilities and substance abuse system has served over the past five state fiscal years, according to the LMEs' data on enrolled consumers. In the following three tables, the number of persons served is determined from data submitted to the Division's Client Data Warehouse (CDW) by the LMEs.[2]

Based on data the LMEs submit, Table 1.1.a. shows that the number of persons who have been served in the community over the past five state fiscal years experienced a slight increase from SFY 2003-04 to SFY 2004-05, but has decreased nine percent since that time. This decrease is, at least in part, due to changes in data submission and data sharing policies. Due to confidentiality laws, the LMEs are dependent on providers' reports to them about individuals receiving Medicaid-funded substance abuse services and do not have independent information for verification. In addition, in SFY 2005-06 the Division began requiring LMEs to complete a discharge record on consumers who had not received any service for sixty days (or 365 days for adult mental health consumers in recovery) in order to improve the

[2] SFY 2007-08 numbers are based on preliminary data. Official numbers for total persons served in SFY 2007-2008 will be available in November 2008 and will be updated in future reports. The numbers for SFY 2006-2007 have been updated since the Fall 2007 Report.

accuracy of data on persons being *actively* served. As expected, this has resulted in the closing of *inactive* records, which is reflected in the decrease since the implementation of this requirement.

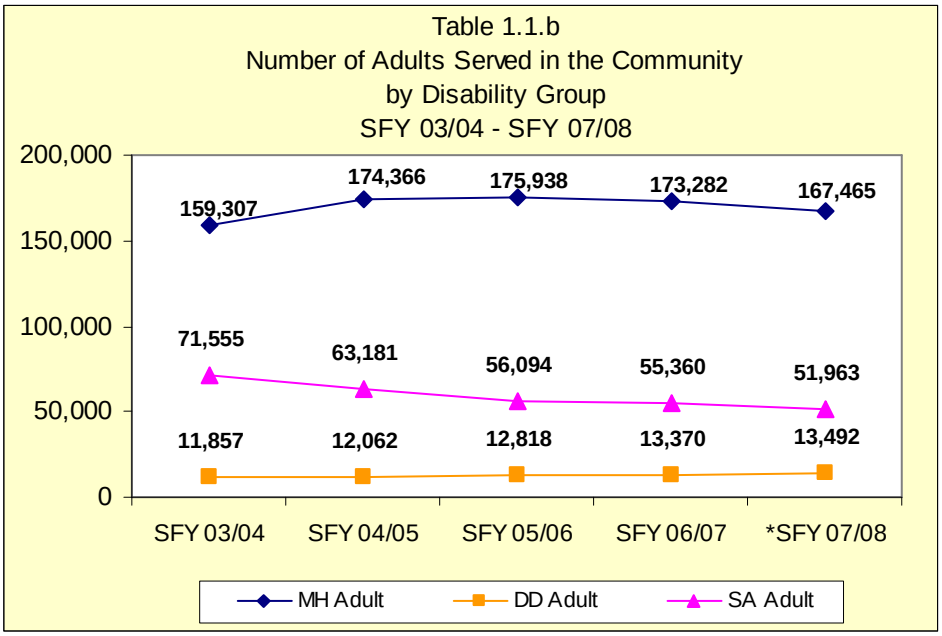


SOURCE: DMH/DD/SAS's Client Data Warehouse. July 1, 2003 - June 30, 2008.

Table 1.1.b. on the next page, shows differing patterns by disability for the number of adults who have been served in the community over the past five state fiscal years. These patterns mirror those found in analysis of service claims data.

- **Adults with a primary mental health diagnosis:** The number of adults served in the community over the past five years has increased by 5%.
- **Adults with a primary developmental disability diagnosis:** The number of adults served in the community over the past five years has increased by 14%.
- **Adults with a primary substance abuse diagnosis:** The number of adults served in the community over the past five years has decreased by 27%.

It is encouraging to see services to adults with mental health problems and developmental disabilities increasing over the past five years. Although persons receiving substance abuse prevention or early intervention services are not included in the reported numbers, the continued downward trend in treatment services to adults with substance abuse problems in the last five years remains a major concern.

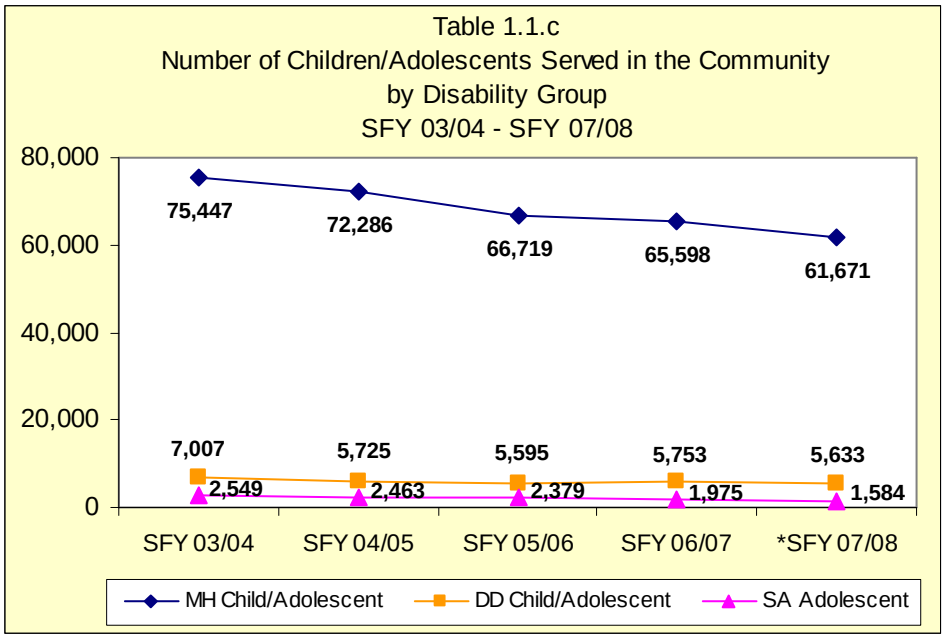


SOURCE: DMH/DD/SAS's Client Data Warehouse. July 1, 2003 - June 30, 2008.

Table 1.1.c, on the next page, shows the number of children and/or adolescents who received state-funded services in the community over the past five state fiscal years as indicated by the LMEs' enrollment data. All of the disability groups saw a decrease in the number of children and/or adolescents served in the community over the past five years with the greatest decline seen in substance abuse services to adolescents.

- **Children/Adolescents with a primary mental health diagnosis:** The number of children and adolescents served in the community over the past five years has decreased by 18%.
- **Children/Adolescents with a primary developmental disability diagnosis:** The number of children and adolescents served in the community over the past five years has decreased by 20%.
- **Children/Adolescents with a primary substance abuse diagnosis:** The number of adolescents served in the community over the past five years has decreased by 38%.

The pattern for children and adolescents receiving mental health and developmental disability services is at least in part a reflection of data sharing policies and efforts to improve data accuracy, as cited above. This assertion is supported by analysis of the service claims data that shows an increase in children and adolescents receiving *active* services during SFY 2007-08. However, similar to the pattern for adults, service claims data show a decline in substance abuse services to adolescents similar to that reported in Table 1.1.c.



SOURCE: DMH/DD/SAS's Client Data Warehouse. July 1, 2003 - June 30, 2008.

The Division is working closely with LMEs and providers to develop and implement strategies to better identify and engage children and adolescents with substance abuse problems.

Measure 1.2: Timeliness of Initial Service

Timeliness of Initial Service is a nationally accepted measure[3] that refers to the time between an individual's call to an LME or provider to request service and their first face-to-face service. A system that responds quickly to a request for help can prevent a crisis that might otherwise result in greater trauma to the individual and more costly care for the system. Responding when an individual is ready to seek help also supports his or her efforts to enter and remain in services long enough to have a positive outcome.

Individuals who request care during crisis situations are usually seen very quickly. In the last quarter of SFY 2007-08:

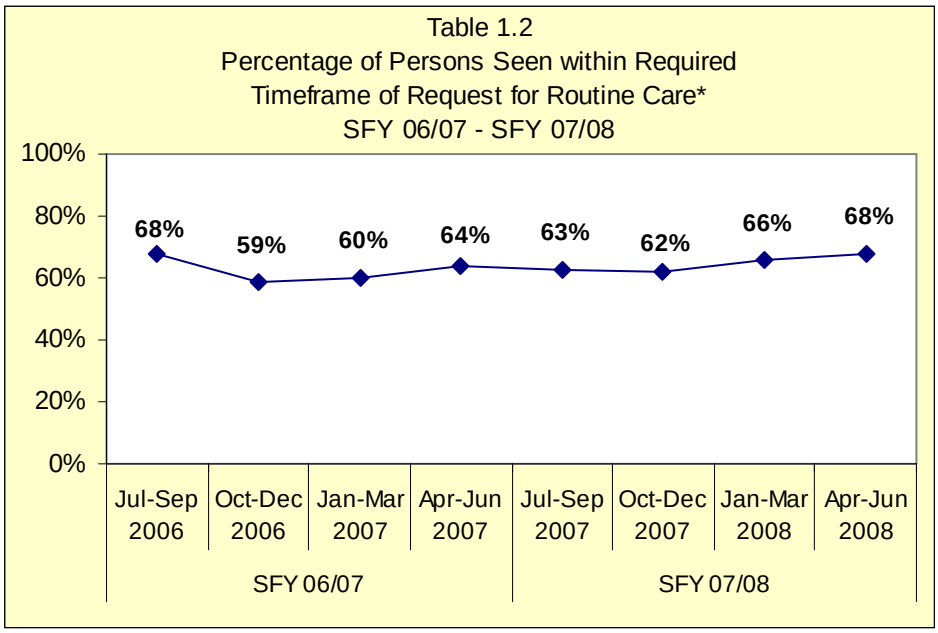
- 99.6% of those requesting care in emergency situations were seen within two hours.
- 78.8% of those requesting care in urgent situations were seen within 48 hours.

In the last quarter of SFY 2007-08, the percent of persons requesting routine (non-urgent) services who were *offered an appointment* within 14 calendar days was 88%. However, not all individuals keep those appointments (only 68% of consumers were seen, as shown in Table 1.2 on the next page). Follow-up by the LME or provider is often necessary to ensure that individuals keep or reschedule appointments.

Looking over time, the percentage of all consumers seeking routine care over the past two state fiscal years who were *actually seen* by a provider within the required timeframe of requesting services has

[3] Health Plan Employer Data and Information Set (HEDIS©) measures.

fluctuated from a low of 59% in the second quarter of SFY 2006-07 to a high of 68% (which occurred during the first quarter of SFY 2006-07 and the fourth quarter of SFY 2007-08).



SOURCE: Data from LME screening, triage, and referral logs submitted to the NC Division of MH/DD/SAS, published in Quarterly Performance Contract reports.
*NOTE: Prior to January 2008, the required timeframe was 7 calendar days. Beginning January 2008, the required timeframe changed to 14 calendar days.

Further improvements on this measure of access will require more stability within the community-based provider system and better coordination between the LMEs and their providers. The Division expects LMEs to have systems in place to schedule an appointment with an appropriate provider while the individual requesting care is still on the telephone and to follow up with individuals who miss appointments. The Division will continue monitoring the LMEs' progress in this matter as part of the *DHHS-LME Performance Contract*. **As a result of this monitoring and efforts to stabilize the provider system, the Division expects performance on this measure to continue to improve.**

Domain 2: Individualized Planning and Supports

Individualized Planning and Supports refers to the practice of tailoring services to fit the needs of the individual rather than simply providing a standard service package. It addresses an individual's and/or family's involvement in planning for the delivery of appropriate services. Services that focus on what is important to individuals (and to their families when appropriate) are more likely to engage them in service and encourage them to take charge of their lives. In addition, services that address what is important for them produce good life outcomes more efficiently and effectively.

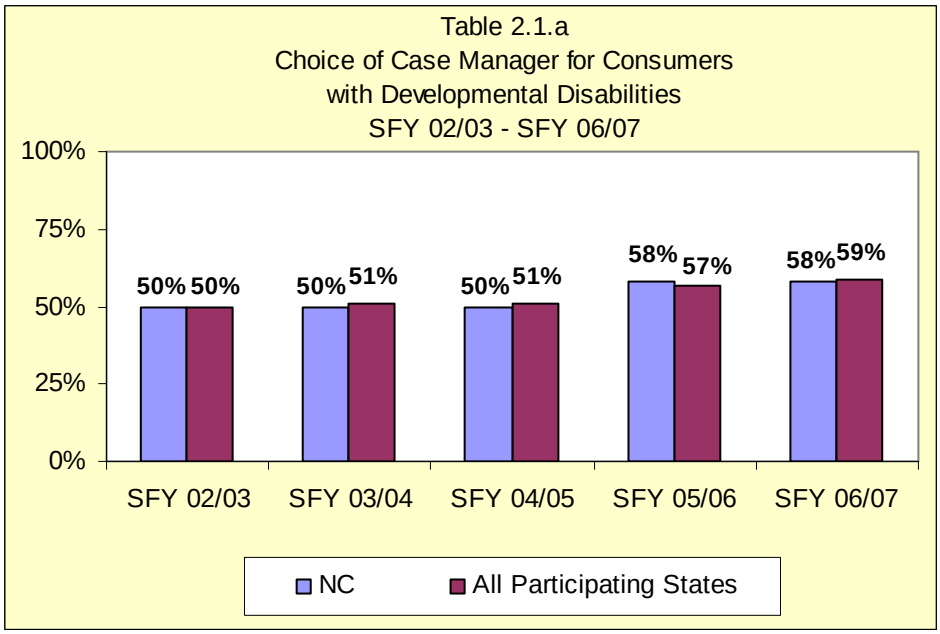
The CMS Quality Framework encourages measuring the extent to which consumers are involved in developing their service plans, have a choice among providers, and receive assistance in obtaining and moving between services when necessary.

Measure 2.1: Consumer Choice of Providers

Offering choices is the initial step in honoring the individualized needs of persons with disabilities. The ability of a consumer to exercise a meaningful choice of providers depends first and foremost on having a

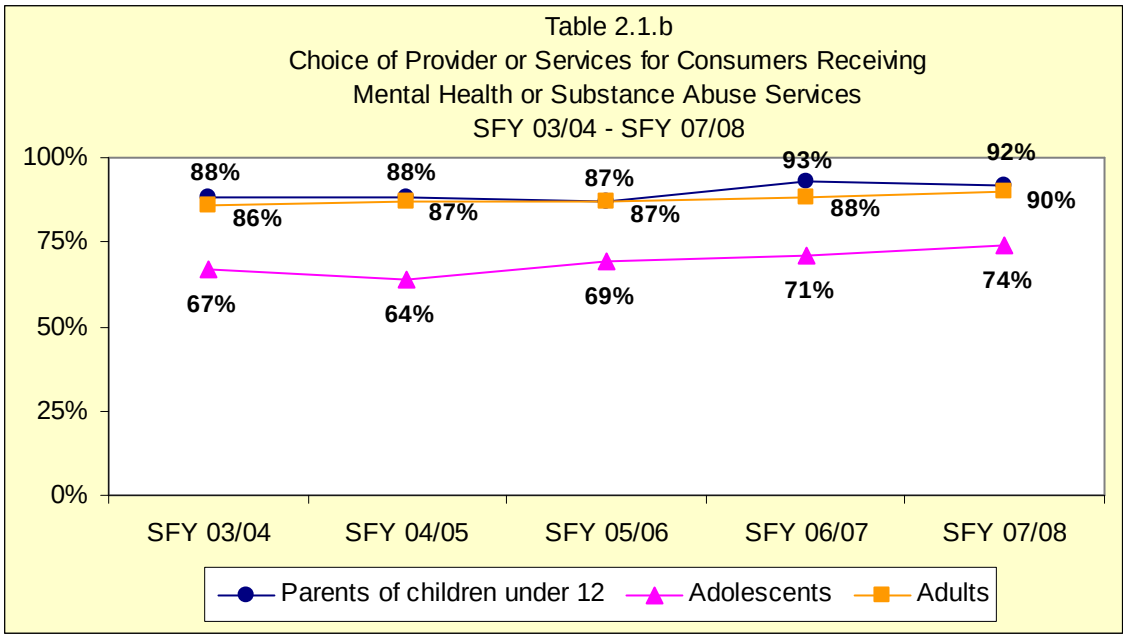
sufficient number of qualified providers to serve those requesting help. In addition, having a voice in the service and staff person(s) that feel most supportive can mean the difference between willing engagement in services or discontinuation of services before recovery or stability can be achieved. With sufficient provider capacity, consumers have an opportunity to select services from agencies that can meet their individual scheduling and transportation requirements, address their individual needs effectively and encourage them in a way that feels personally comfortable and supportive. The tables on the following pages address the extent to which individuals report having a choice in who serves them and/or the services they receive.

Consumers with Developmental Disabilities (Table 2.1.a): In annual interviews with DD consumers, at least half of the individuals in North Carolina reported choosing their case manager as shown in Table 2.1.a. Over the past five years, North Carolina was approximately the same as the average among all states using the survey. (See Appendix C for details on the National Core Indicators Project's Consumer Survey.) Since SFY 2002-03, there has been an eight percent increase in consumer choice of case manager for both individuals in North Carolina as well those for all participating states.



SOURCE: National Core Indicators Project, Consumer Survey. Project Year 2006-07.

Consumers with Mental Health and Substance Abuse Disabilities (Table 2.1.b): In the annual Division survey of persons with mental health or substance abuse disabilities, a large majority reported positive feedback regarding choosing their providers and the services they received. This positive trend has increased slightly over the past five years of the consumer survey among adults, adolescents as well as parents of children under the age of twelve. Adolescents were less likely than these two groups to report helping to choose their services, but have shown the greatest increase in choice of provider in the last five years (an increase of seven percent over five years). (See Appendix C for more information on the Mental Health Statistical Improvement Project Consumer Survey.)



SOURCE: Mental Health Statistical Improvement Project Consumer Survey (MHSIP-CS)

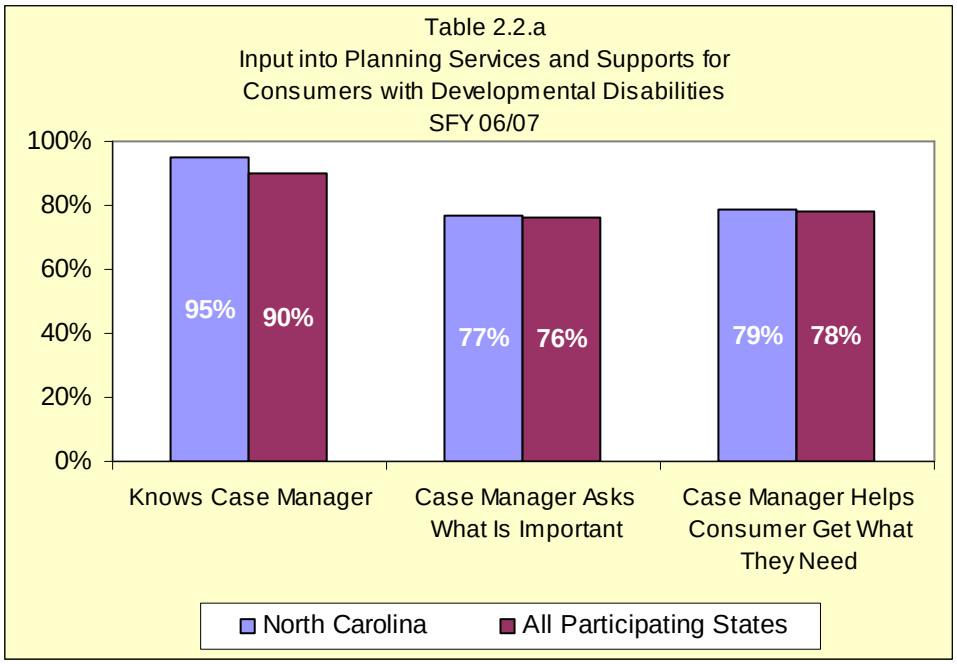
These results provide encouragement that system reform is offering opportunities for consumers to have input into their services. **The Division expects the current positive trends to continue on this measure.**

Measure 2.2: Person-Centered Planning

A Person-Centered Plan (PCP) is the basis for individualized planning and service provision. It allows consumers and family members to guide decisions on what services are appropriate to meet their needs and goals and tracks progress toward those goals. Having a voice in choosing personally meaningful goals is a critical step toward recovery and self-determination. The Division requires a PCP for most persons who receive enhanced benefit services,[4] and has implemented a standardized format and training to ensure statewide adoption of this practice. As the following tables show, a large majority of consumers are involved in the service planning and delivery process.

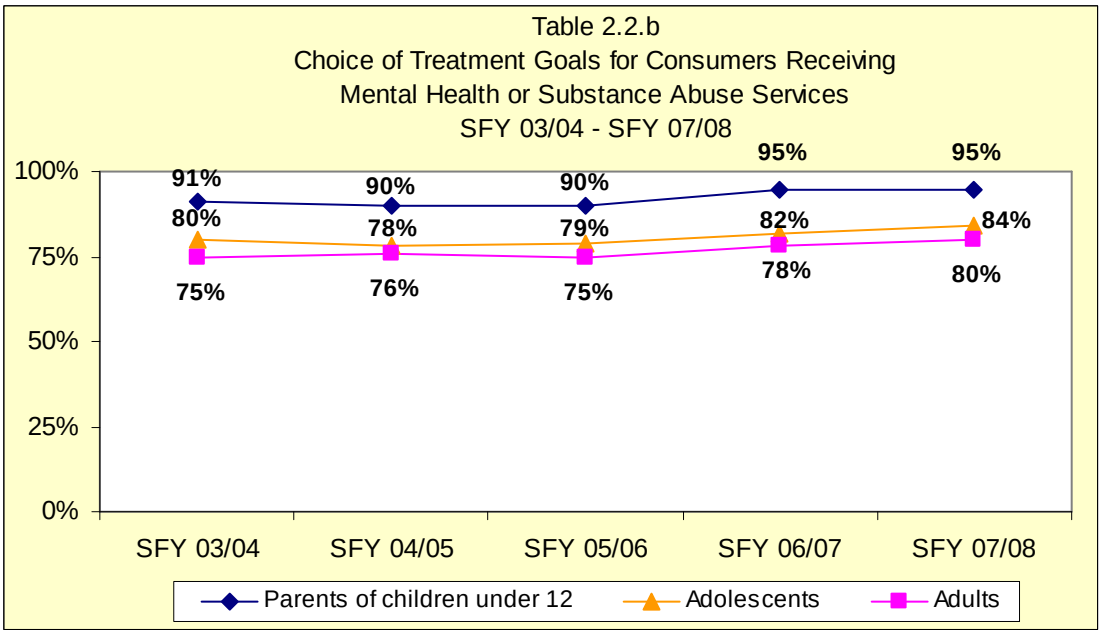
Consumers with Developmental Disabilities (Table 2.2.a): In three key areas related to service planning, the large majority of North Carolina consumers with developmental disabilities reported having input into their services and assistance in getting what they need as shown in Table 2.2.a on the next page. North Carolina consumers responded much like consumers in other states using this survey. (See Appendix C for more information on this survey.)

[4] "The enhanced benefit service definition package is for persons with complicated service needs." *State MH/DD/SAS Plan 2005*, p. 58.



SOURCE: National Core Indicators Project, Consumer Survey. Project Year 2006-07.

Consumers with Mental Health and Substance Abuse Disabilities (Table 2.2.b): Every year in a consumer survey the Division asks mental health and substance abuse consumers about their having a choice of treatment goals. As Table 2.2.b shows, the vast majority of mental health and substance abuse consumers in the annual survey have consistently reported choosing or helping to choose their treatment goals across all groups reporting: parents of children under the age of 12, adolescents, and adults. Adults reported having less input into their treatment goals compared to parents of children under the age of 12 and adolescents, but like the other two age groups, have shown some improvement over the past five years.



SOURCE: Mental Health Statistical Improvement Project Consumer Survey (MHSIP-CS)

The state has made immense efforts to institute a system of care that strongly encourages consumer and family participation in service planning and delivery. The Division, LMEs and providers must continue to incorporate person-centered thinking into all aspects of the service system. This is a major shift in philosophy that will require time, diligence and collaboration to achieve fully. The *DHHS-LME Performance Contract SFY 2008-2009* requires each LME to review consumers' PCPs to ensure the appropriateness of services and progress toward recovery and community stability. **As a result of these LME activities and continued learning among all parties in the service system, the Division expects to see this positive trend continue to improve in coming years.**

Domain 3: Promotion of Best Practices

This domain refers to adopting and supporting those models of service that give individuals the best chance to live full lives in their chosen communities. It includes support of community-based programs and practice models that scientific research has shown to result in improved functioning of persons with disabilities, as well as promising practices that are recognized nationally. SAMHSA requires states to report on the availability of evidence-based practices as part of the National Outcome Measures.

Supporting best practices requires adopting policies that encourage the use of natural supports, community resources and community-based service systems; funding the development of evidence-based practices; offering incentives to providers who adopt those practices and providing oversight and technical assistance to ensure the quality of those services.

The North Carolina Practice Improvement Collaborative (NC PIC) provides guidance to the Division in determining the evidence-based practices that will be provided through our public system. With representatives of all three disabilities, the NC PIC meets quarterly to review and discuss practices that have been submitted for evaluation, examine issues that affect the readiness of the practice for adoption in our state, and to prioritize recommendations for the Division Director.

Measure 3.1: Persons Receiving Evidence-Based Practices

Consumers with Developmental Disabilities: The Division, in collaboration with the Division of Medical Assistance (DMA) has implemented a 1915(c) Home and Community-Based Waiver for persons with developmental disabilities who are funded by Medicaid since September 2005. The current waiver, known as the Community Alternatives Program for MR/DD or CAP-MR/DD Waiver will expire October 31, 2008.

The two Divisions are creating a system of tiered waivers to be implemented over the next several years. The development of the tiered waivers is an opportunity to enhance best practice approaches to delivering services and supports for individuals who experience developmental and intellectual disabilities. The first two waivers – the Supports Waiver and the Comprehensive Waiver – were submitted to the federal Center for Medicare and Medicaid Services in August 2008 and will be implemented on November 1, 2008, *pending CMS approval.*

Objectives of the Supports Waiver and the Comprehensive Waiver include:

- Enhancing the focus on person-centered planning and the alignment of services and supports with person-centered plans;
- Reforming day supports, supported employment, and long term vocational supports to ensure that participants are progressing towards their employment goals, have meaningful daily activities;

- Reforming residential service to facilitate smaller community congregate living situations;
- Facilitating consumers' goals to live and work in the most integrated setting; and
- Improving outcome-based quality assurance systems.

The *Supports Waiver* is intended for individuals who live in their own home or reside with their family with some support; and individuals who live in licensed residential facilities. Self-direction is an option in this waiver for individuals living in their own home or with their family that moves the service system forward and further encourages individualization of services and supports. The Supports Waiver contains an annual cost limit of $17, 500.

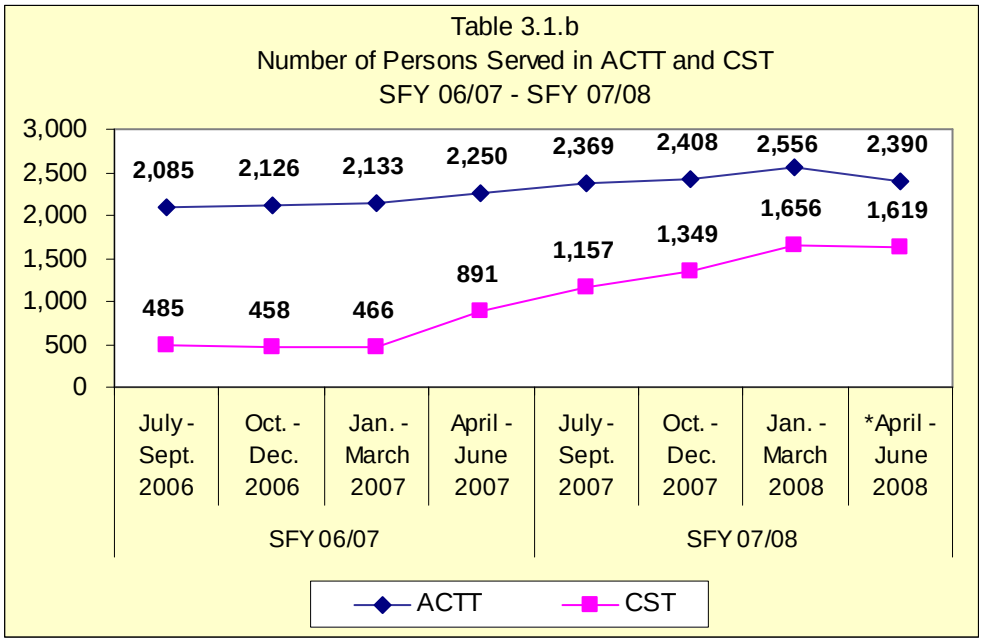
The *Comprehensive Waiver* is intended for individuals who reside in their own home; reside with their family; or receive residential services in community congregate settings in the community. The Comprehensive Waiver contains an annual cost limit of $135,000.

These tiered waivers will provide service definitions tailored to the needs of the specific population of each waiver and will further support individualize services and supports. Many of the existing service definitions (contained in the current waiver) have been revised to ensure that components meet best practice standards for services and supports for individuals with intellectual and developmental disabilities. In addition, new services have been developed to provide additional options and more refined services and supports.

Person centered planning is paramount for success in creating a system that is responsive to the needs of individuals. The Supports Intensity Scale (SIS) is a strengths-based assessment tool that is being implemented to help planners identify the supports necessary to enable the individual to participate fully in their community. Management and oversight of the waivers will include use of data provided through the SIS on those individuals receiving services and supports through the tiered waivers. This data can help the Divisions and LMEs to plan and support individuals with developmental disabilities more effectively. The Division is currently piloting the SIS in seven LMEs, in preparation for full implementation after the waivers are initiated.

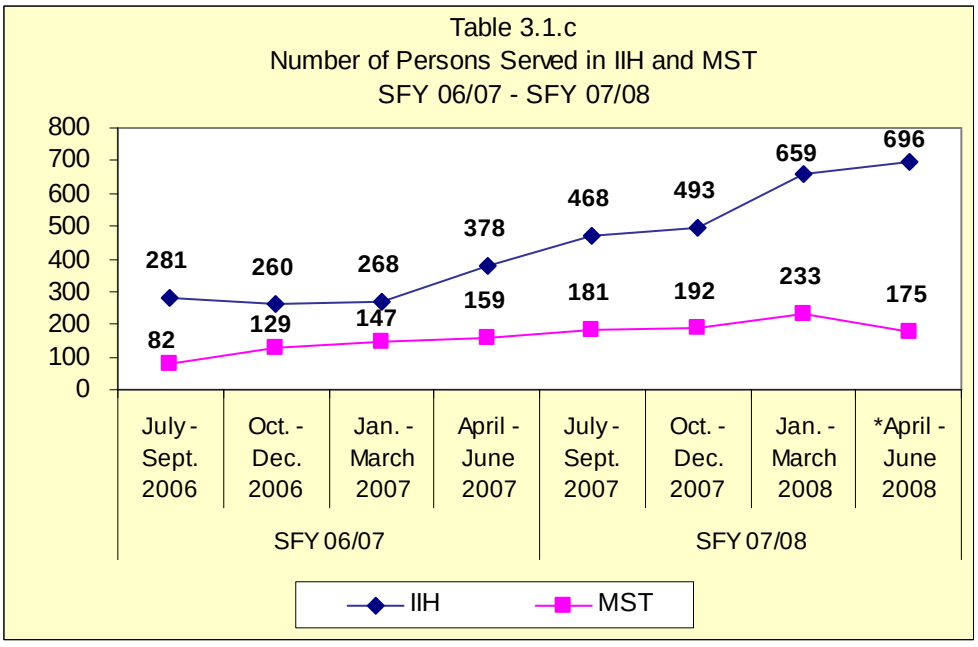
The goal of the tiered waivers is to enhance best practice approaches in the system of services and supports for individuals with intellectual and developmental disabilities. The Division expects these waivers to move the state forward in creating a service system that is responsive to the needs of individuals receiving services.

Consumers with Mental Health Disabilities: Adults with severe and persistent mental illnesses often need more than outpatient therapy or medications to maintain stable lives in their communities. Community support teams (CST) and assertive community treatment teams (ACTT) are designed to provide intensive, wrap-around services to prevent frequent hospitalizations for these individuals and help them successfully live in their communities. As shown in Table 3.1.b on the next page, the number of adults served in ACTT has been increasing steadily the past two years (an increase of 15% since the first quarter of SFY 2006-07), while the number of adults served in CST has increased fourfold during the past two state fiscal years. **The Division expects to see continued improvements in the availability and use of CST.**



SOURCE: Medicaid and State Service Claims Data. July 1, 2006 - June 30, 2008.
*NOTE: Data reported in the fourth quarter of SFY 2007-08 is incomplete due to insufficient time for claims to be submitted and paid.

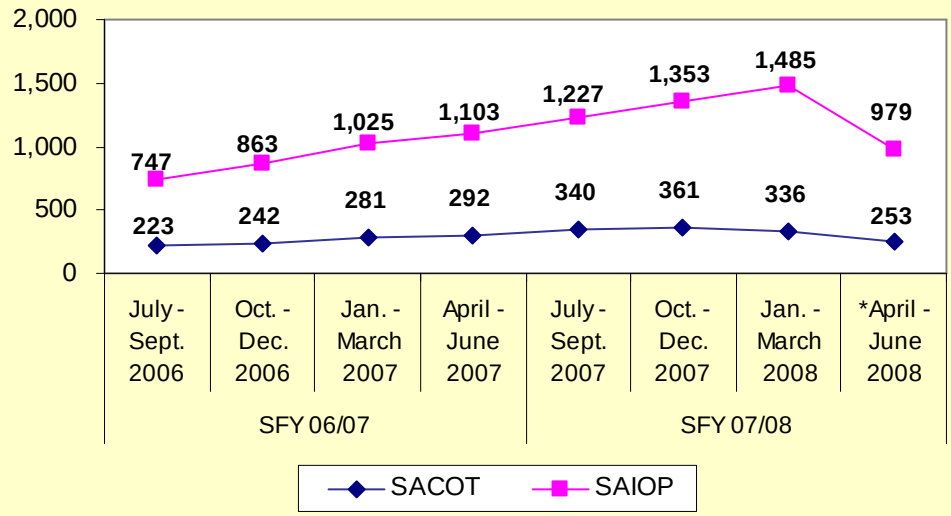
Best practice services that support community living for children and adolescents with severe emotional disturbances and/or substance abuse problems require involvement of the whole family. Two of these best practices – intensive in-home (IIH) and multi-systemic therapy (MST) – help reduce the number of children who require residential and inpatient care. Table 3.1.c shows that the number of persons served in IIH has increased 148% during the past two fiscal years. Likewise, the number of persons served in MST has more than doubled since the first quarter of SFY 2006-07. The Division is currently working to ensure the appropriate use of community support services and to identify children and adolescents who would be better served through IIH services. **As a result of these efforts, the Division expects to see the IIH to continue growing, as the use of community support continues to decline.**



SOURCE: Medicaid and State Service Claims Data. July 1, 2006 - June 30, 2008.
*NOTE: Data reported in the fourth quarter of SFY 2007-08 is incomplete due to insufficient time for claims to be submitted and paid.

Consumers with Substance Abuse Disabilities: Recovery for individuals with substance abuse disorders requires service to begin immediately when an individual seeks care and to continue with sufficient intensity and duration to achieve and maintain abstinence. The substance abuse intensive outpatient program (SAIOP) and comprehensive outpatient treatment (SACOT) models support those intensive services using best practices, such as motivational interviewing techniques. While SAIOP and SACOT have seen increases in the number of persons served during the last two state fiscal years, it appears the number of persons served in both services dropped in the last quarter of SFY 2007-08 (see Table 3.1.d below). Whether this is due to delay in claims submission or a drop in services provided is unclear. SACOT had the highest number of persons served in the latter part of 2007 with 361 persons served that quarter and SAIOP had the highest number of persons served in the early part of 2008 with 1,485 persons served that quarter.

Table 3.1.d
Number of Persons Served in SACOT and SAIOP
SFY 06/07 - SFY 07/08



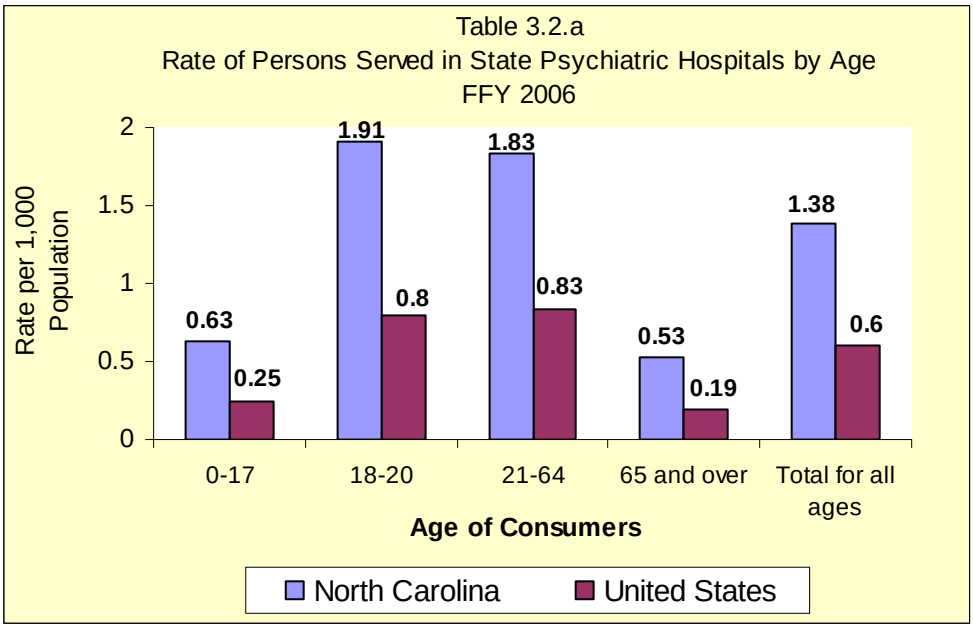
SOURCE: Medicaid and State Service Claims Data. July 1, 2006 - June 30, 2008.
*NOTE: Data reported in the fourth quarter of SFY 2007-08 is incomplete due to insufficient time for claims to be submitted and paid.

Measure 3.2: Use of State Operated Services

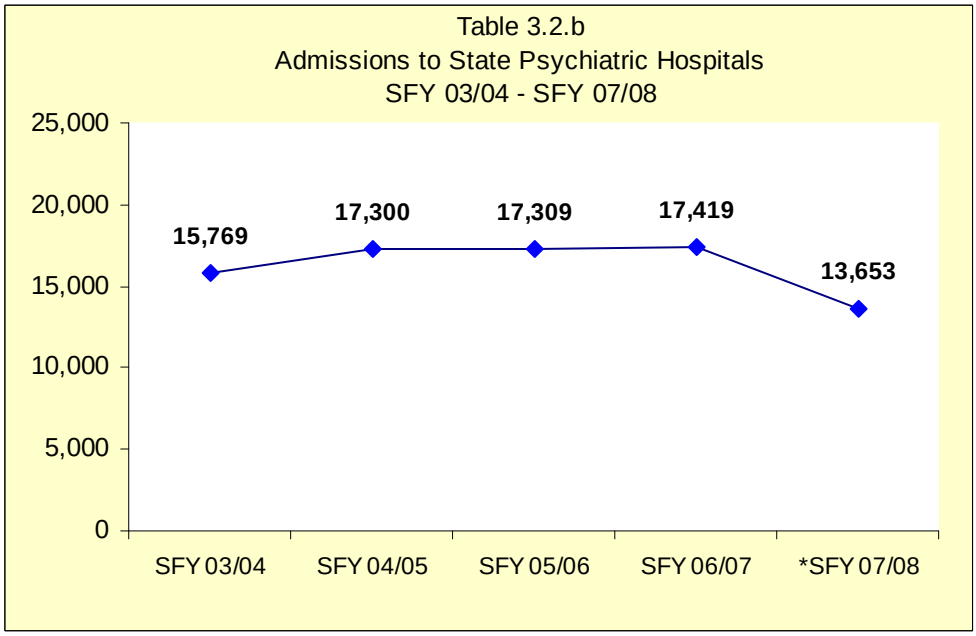
A service system in which individuals receive the services and supports they need in their home communities allows them to stay connected to their loved ones. This is a particularly critical component of recovery or self-determination in times of crisis. Service systems that concentrate on preventing crises and providing community-based crisis response services can help individuals maintain support from their family and friends, while reducing the use of state-operated psychiatric hospitals in times of acute crisis.

As stated in previous reports, North Carolina has historically used its state psychiatric hospitals to provide more short-term care (30 days or less) than other states. In most other states, acute care is provided in private hospitals, reserving the use of state psychiatric hospitals for consumers needing long-term care. North Carolina, however, has historically served more people overall in its state psychiatric hospitals than other states and with shorter average lengths of stay.

According to Table 3.2.a North Carolina has continued to provide treatment for persons in its state psychiatric hospitals at more than twice the national rate across all ages, according to the most recent report (federal fiscal year (FFY) 2006) from the Center for Mental Health Services (CMHS). A fundamental goal of the state's system reform efforts has been to reduce the short-term use of state psychiatric hospitals. **The Division expects to see this measure positively impacted in coming years by the ongoing implementation of crisis plans by all LMEs.**



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Data as reported in the North Carolina Community Mental Health Block Grant report, FFY 2006.

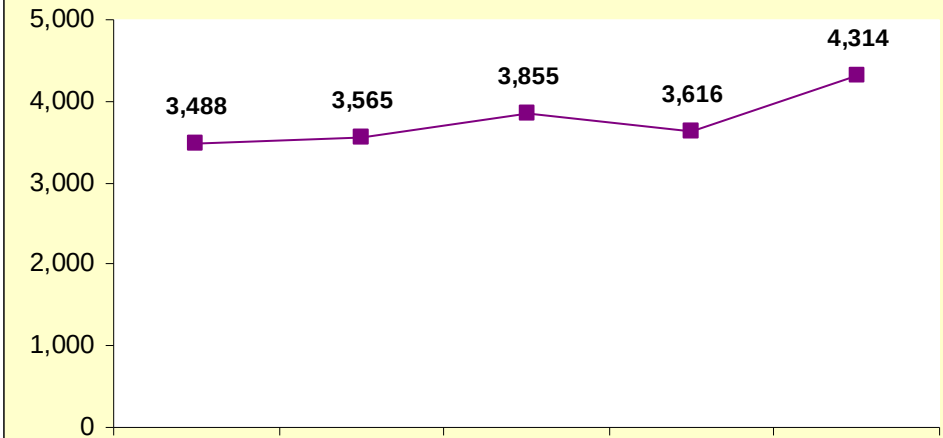


SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Data for state psychiatric hospital admissions during July 1, 2003 - June 30, 2008.

Over the past five years, the number of admissions to the state psychiatric hospitals has begun to stabilize, as shown in Table 3.2.b.[5] The greatest increase in admissions occurred between SFY 2003-04 and SFY 2004-05, when admissions rose by 10%. From SFY 2004-05 until SFY 2006-07, the number of admissions stabilized and in the past state fiscal year (SFY 2007-08) admissions decreased approximately 22%. When state hospitals are at capacity, there is a delay in admissions, which explains the sharp decrease this past fiscal year. With new funds appropriated by the Legislature, the development of community inpatient capacity will help to reduce hospital admissions in the future. **The Division expects consolidation of the hospitals and ongoing efforts by the Division, LMEs, and providers to improve local crisis systems to reduce the number of admissions in the future.**

In contrast to efforts to *reduce* the use of state psychiatric hospitals for short-term care, the Division continues working to *increase* the use of state alcohol and drug treatment centers (ADATCs) for acute care. ADATCs are critical resources to serve individuals who are exhibiting primary substance abuse problems that are beyond the treatment capacity of local community services, but for whom psychiatric hospitalization is not appropriate. As shown in Table 3.2.c below, total admissions to all ADATCs has climbed steadily from 3,488 in SFY 2003-04 to 4,314 in SFY 2007-08 (a 19% increase).[6] **The Division expects that the opening of new acute units in the near future will result in a greater use of ADATCs for detoxification and short-term care and a decrease in inappropriate admissions of primary substance abuse consumers to psychiatric hospitals.**

Table 3.2.c
Admissions to ADATCs
SFY 03/04 - SFY 07/08



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Data for ADATC admissions during July 1, 2003 - June 30, 2008.

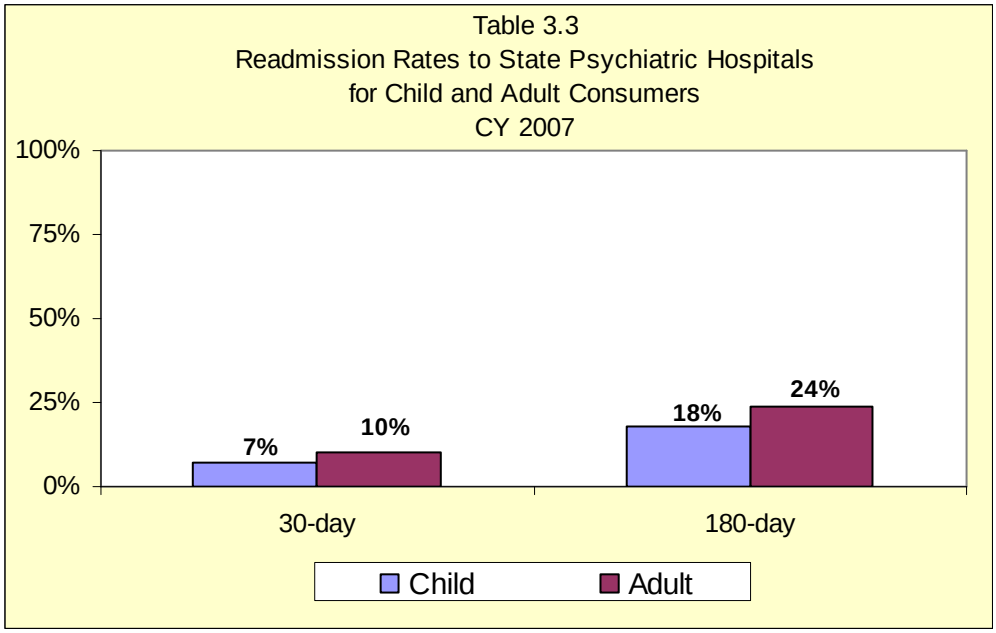
[5] The numbers for SFY 2007-08 are preliminary. They will be final in November 2008 and updated in future reports.

[6] The numbers for SFY 2007-08 are preliminary. They will be final in November 2008 and updated in future reports.

Measure 3.3: State Psychiatric Hospital Recidivism

An effective service system provides enough support to help prevent consumer crises and minimize their impact through appropriate planning and treatment. Recurring hospitalization for persons who are likely to experience frequent crises is a signal that additional supports are needed. Tracking hospital readmissions within 30 days of discharge is a critical measure of consumer care (adopted by SAMHSA's Center for Mental Health Services) that provides the Division with information on where more comprehensive services might be needed.

Table 3.3 shows the percent of child and adult consumers requiring readmission to state hospitals within 30 days and 180 days of discharge. For both child and adult, the readmission rates more than double when extending the follow-up period from 30 days to 180 days. Also, as seen in the table below, state psychiatric hospital readmissions for child consumers are lower than that of adult consumers for both the 30-day and 180-day time periods. **The Division expects to see readmissions to state psychiatric hospitals decrease in coming years as access to community crisis services are expanded with funds provided by the Legislature.**



SOURCE: Healthcare Enterprise Accounts Receivable Tracking System (HEARTS) Data for HEARTS Discharges January 1, 2007 - December 31, 2007.

Measure 3.4: Transitions to Community from State Developmental Centers

The Division is committed to increasing opportunities for individuals with developmental disabilities to live in community settings, when appropriate and desired. Moving from a state developmental center to a community setting requires careful planning and monitoring to ensure a safe and successful transition.

For individuals moving from the state's developmental centers to the community, transition planning begins many months prior to discharge. This involves multiple person-centered planning meetings between the individual, their guardian, the treatment team and the community-based provider that has been selected by the individual and their guardian. Service delivery begins immediately upon leaving the developmental center. In SFY 2007-08, a total of 7 individuals were discharged from the general

population of the developmental centers to the community.[7] All seven individuals went directly from services at the developmental centers to services in the community. Table 3.4 shows the type of community setting to which the individuals moved.

Table 3.4
Follow-Up Care for DD Consumers Discharged from State Developmental Centers
SFY 2007/08

Time Period	Number of Individuals Moved to Community	Type of Community Setting
July – September 2007	3	1 to ICF-MR group home 1 to natural family 1 to alternative family living home
October – December 2007	1	1 to ICF-MR group home
January – March 2008	2	1 to DDA/supervised living home 1 to alternative family living home
April – June 2008	1	1 to ICF-MR group home

The Division is currently developing plans to support more individuals' move to communities of their choice, while ensuring access to necessary crisis and respite services through funds provided by the Legislature. As progress is made on these efforts, the Division expects to see more people discharged from the state-operated developmental centers to community settings with continuation of the thorough pre-discharge planning and transitional care that is currently provided.

Domain 4: Consumer-Friendly Outcomes

Consumer Outcomes refers to the impact of services on the lives of individuals who receive care. One of the primary goals of system reform is building a recovery/stability-oriented service system. Recovery and stability for a person with disabilities means having independence and control over one's own life, being considered a valuable member of one's community and being able to accomplish personal and social goals.

All people – including those with disabilities – want to be safe, to engage in meaningful daily activities, to enjoy time with supportive friends and family, and to participate positively in the larger community. The SAMHSA National Outcome Measures and the CMS Quality Framework include measures of consumers' perceptions of service outcomes and measures of functioning in a variety of areas, including:

- Symptom reduction, abstinence, and/or behavioral improvements
- Housing stability and independence

[7] This number does not include persons discharged from specialty programs or respite care in the developmental centers.

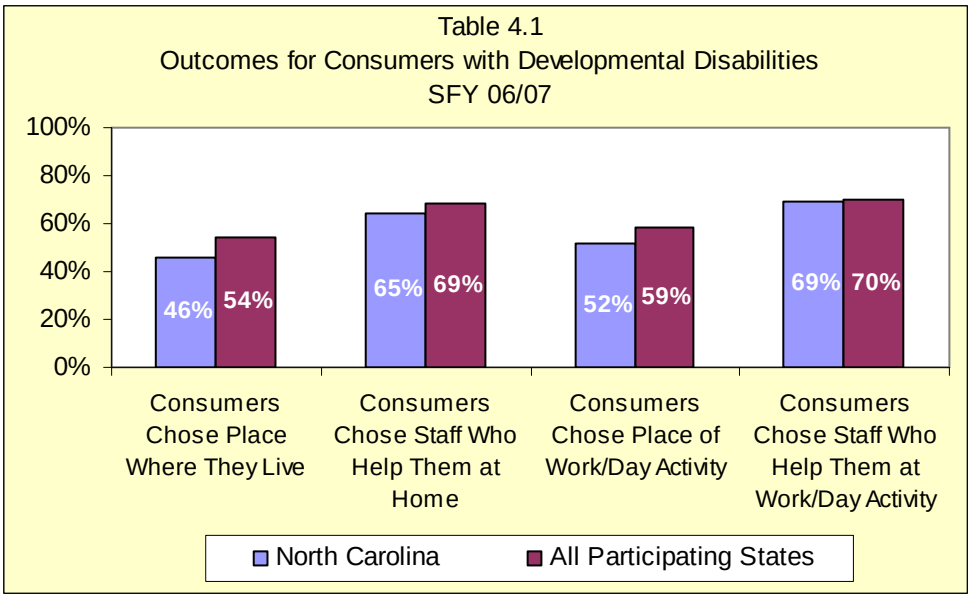
- Employment and education
- Social connectedness
- Reduction in criminal involvement

The Division is currently working to ensure that individual progress on these consumer outcomes is addressed as a regular part of developing person-centered plans for every consumer. Based on analysis of current data on consumer outcomes, the Division has adopted improvements in two of these areas – housing and employment / education – as objectives in the *State Strategic Plan 2007-2010* to be addressed over the next three years.

Measure 4.1: Outcomes for Persons with Developmental Disabilities

As seen in Table 4.1, in annual interviews with DD consumers in SFY 2006-07, the majority individuals in North Carolina reported having input into life decisions, with the exception being slightly less than half reporting choosing the place where they live. (See Appendix C for details on this survey.) Across all four measures related to housing and employment/daily activities, North Carolina was slightly below the average among all states using the survey, but ranked most closely with the measures related to choosing staff to assist individuals at home and at work. While less than half of consumers with developmental disabilities reported choosing where they live, close to two-thirds reported choosing the staff that help them in their home. Approximately five out of ten consumers in North Carolina reported choosing their place of work or day activity and seven out of ten consumers reported choosing the staff who assist them in their work or day activity.

Table 4.1
Outcomes for Consumers with Developmental Disabilities
SFY 06/07

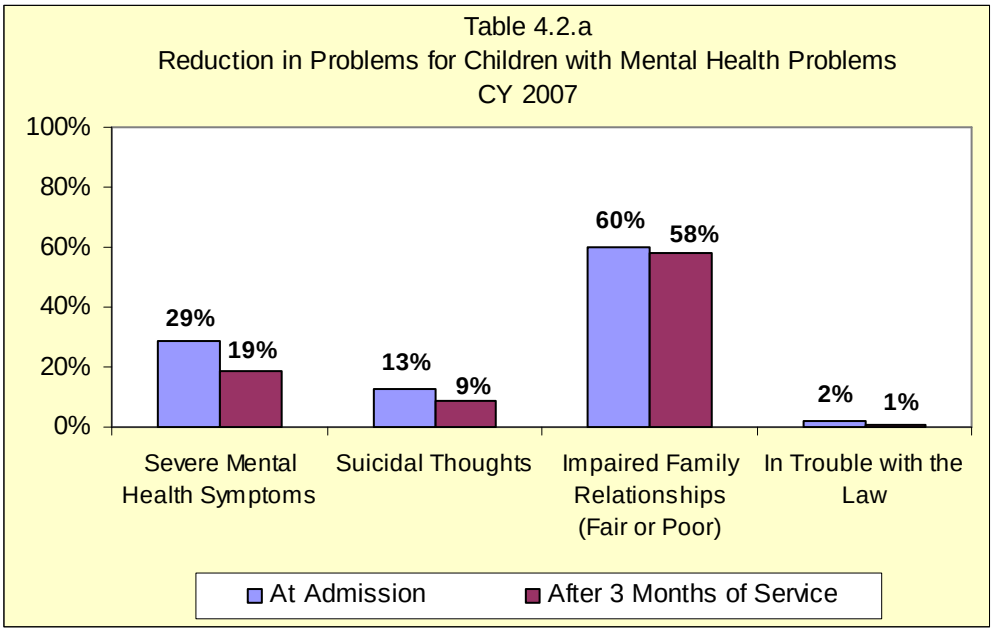


SOURCE: National Core Indicators Project, Consumer Survey. Project Year 2006-07.

Measure 4.2: Outcomes for Persons with Mental Illness

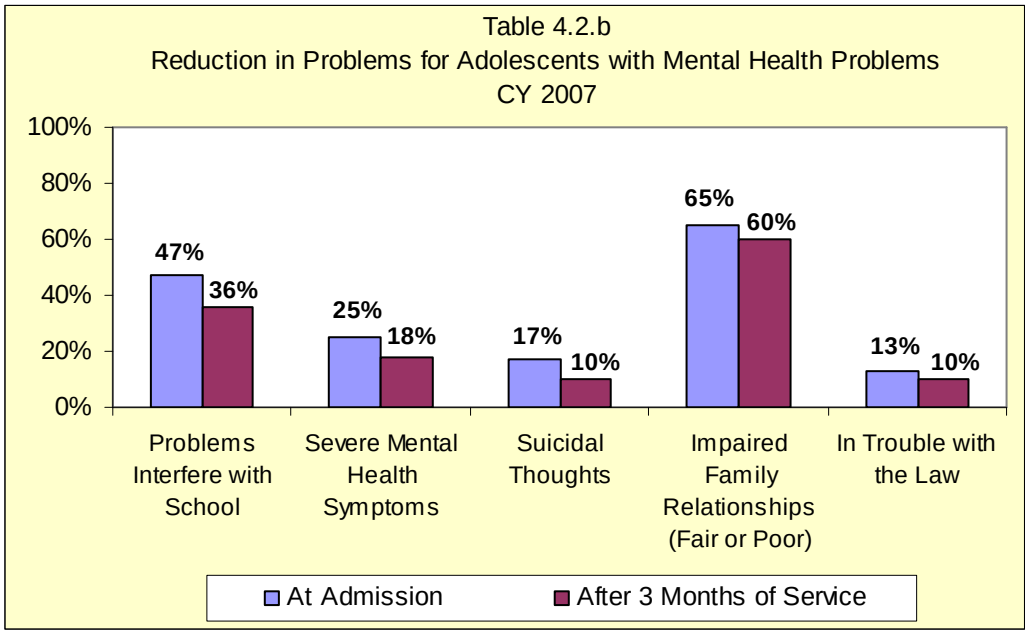
For persons with mental illness, SAMHSA is focusing National Outcome Measures on reducing symptoms that limit consumers' ability to maintain positive, stable activities and relationships. Successful engagement in services for even three months can improve consumers' lives, as shown in data from consumer interviews below. (See Appendix C for details on the NC-TOPPS system used to collect this data.)

Table 4.2.a shows improvement in the lives of children under age 12 with mental health problems (who received three months of treatment during Calendar Year 2007) in the following four areas: severe mental health symptoms, suicidal thoughts, impaired family relationships, and trouble with the law. All of these areas showed improvements after three months of treatment, the most noticeable being a ten percentage point drop in severe mental health symptoms.



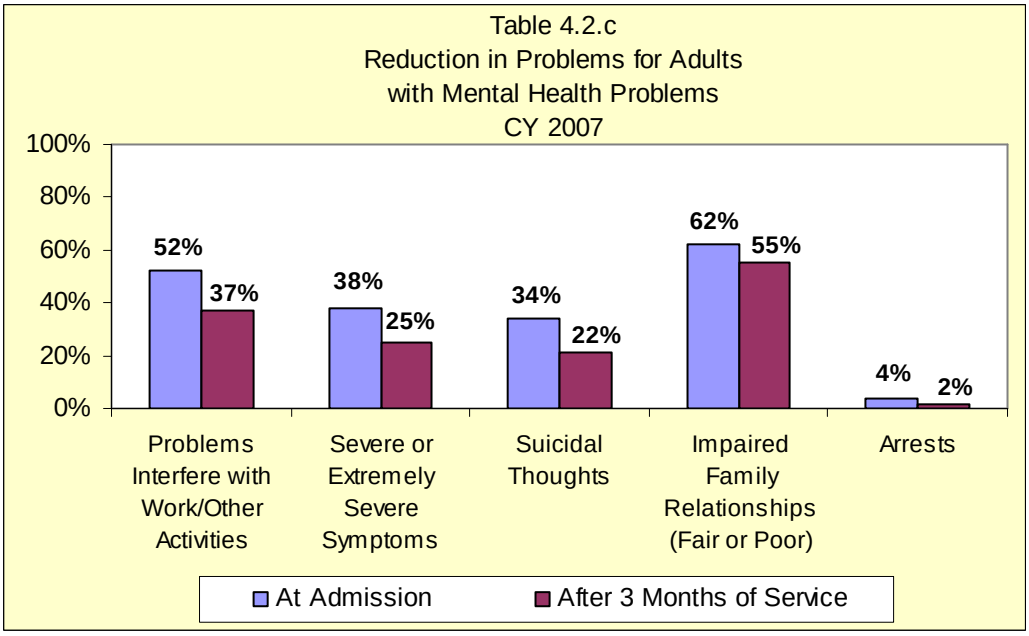
SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted January 1, 2007 - December 31, 2007 matched to 3-Month Update Interviews.

Table 4.2.b on the next page, shows improvement in the lives of adolescents (ages 12 to 17) with mental health problems (who received three months of treatment during Calendar Year 2007) in the following areas: problems in school, severe mental health symptoms, suicidal thoughts, impaired family relationships, and trouble with the law. Adolescents showed improvements in all of these areas after three months of service. The most improvement is seen in an eleven percentage point decrease in adolescents getting in trouble with the law.



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted January 1, 2007 - December 31, 2007 matched to 3-Month Update Interviews.

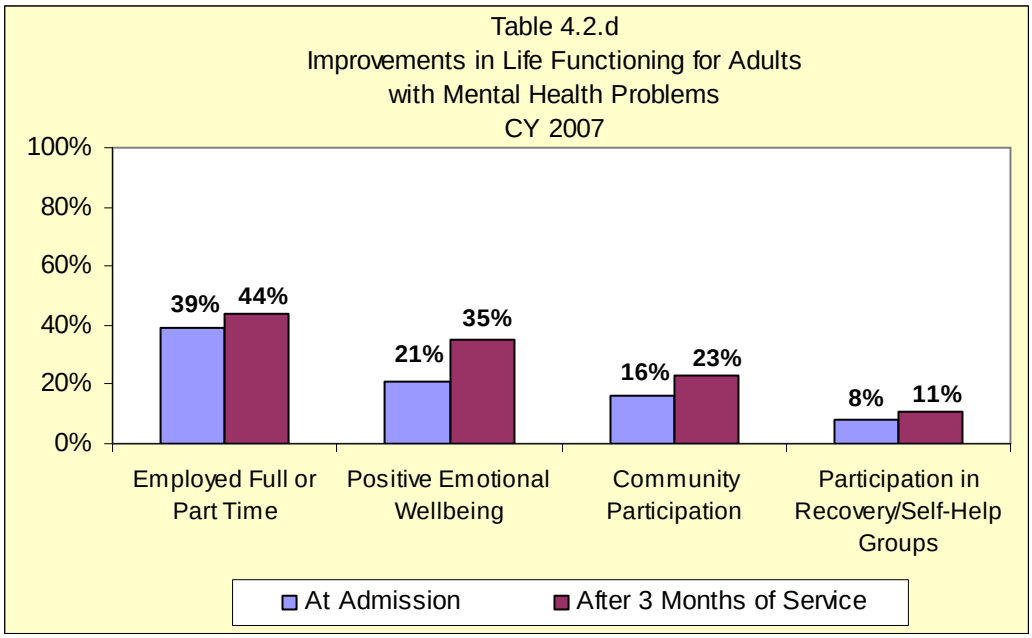
As seen in Table 4.2.c, progress was made in the lives of adults with mental health problems in reducing their symptoms and the problems associated with those symptoms after only three months of treatment. Similar to children, the greatest gain was in reduction of problems with work or other activities (down 15 percentage points). The next greatest improvements were in reducing the severity of mental health symptoms (down 13 percentage points) and suicidal thoughts (down 12 percentage points).



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted January 1, 2007 - December 31, 2007 matched to 3-Month Update Interviews.

Three months of service also made a positive difference in the quality of life for adults with mental health problems as seen in Table 4.2.d below.

- The percent of adults employed full or part-time increased slightly.
- The percent of adults reporting positive emotional wellbeing increased by more than one-half.
- The percent of adults participating in positive community activities increased by almost one-half.
- The percent of adults participating in recovery or self-help groups increased slightly.



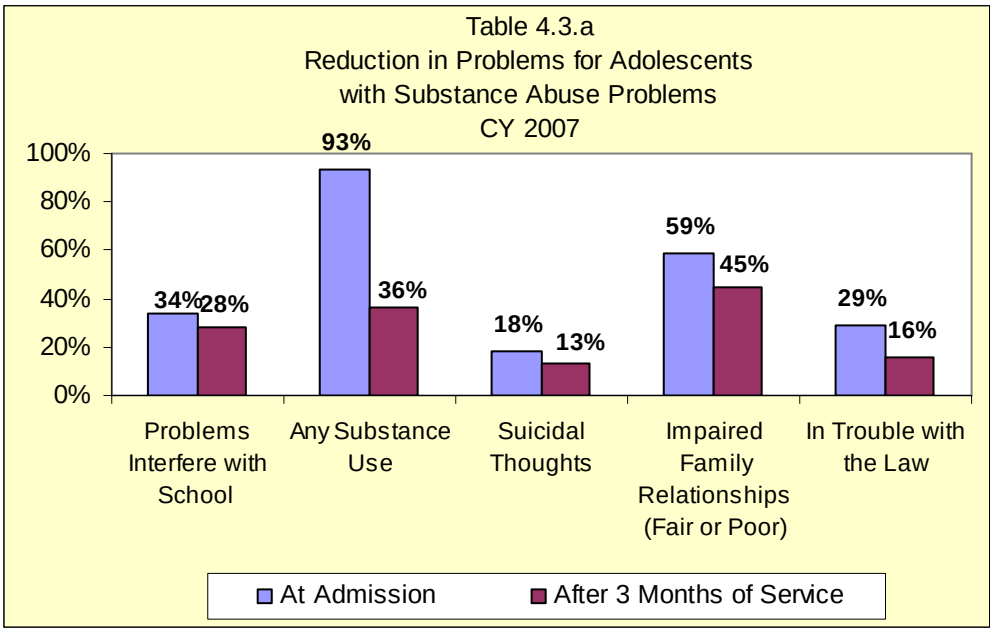
SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted January 1, 2007 - December 31, 2007 matched to 3-Month Update Interviews.

While outcomes for adult mental health consumers are all positive, room for improvement remains, especially in the areas of employment and participation in self-help groups. Adults, as well as children and adolescents, who remain engaged in services for more than three months can be expected to continue improving in all of the areas shown above. **As the Division and local partners develop and implement strategies to improve education and employment outcomes for consumers over the next three years, the Division expects to see long lasting improvements in these areas.**

Measure 4.3: Outcomes for Persons with Substance Abuse Disorders

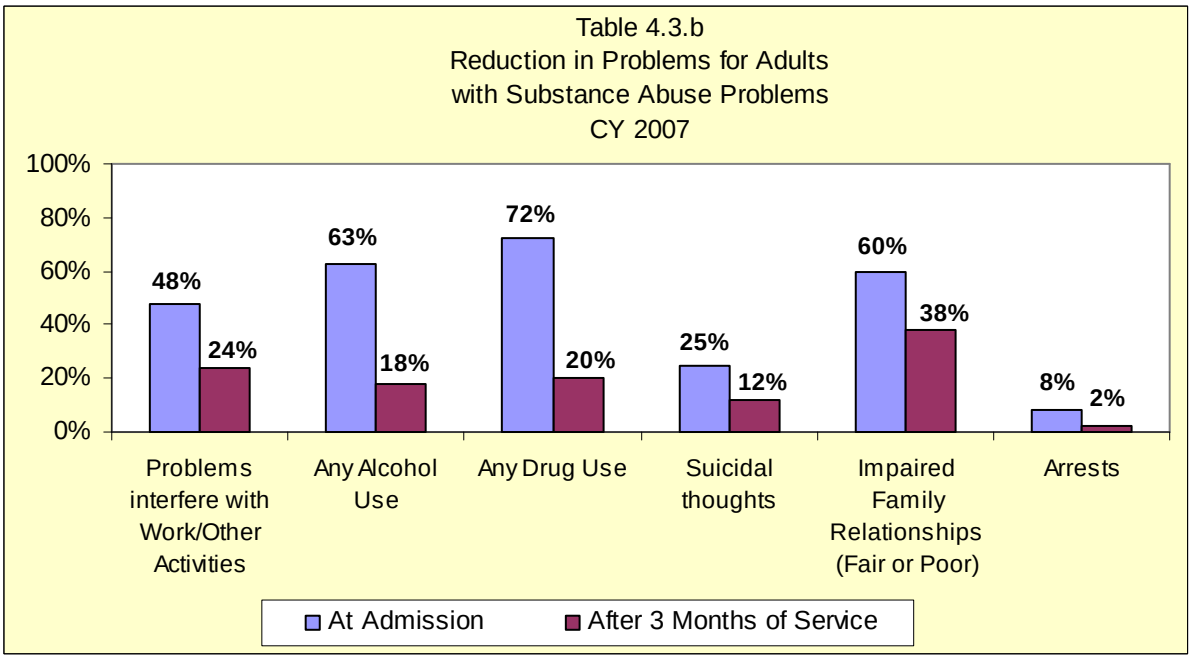
SAMHSA National Outcome Measures for persons with substance abuse problems focus on eliminating the use of alcohol and other drugs in order to improve consumers' well-being, social relationships and activities. Successful initiation and engagement in services with this population can have very positive results in a short time, as shown in the data from consumer interviews below. (See Appendix C for details on the NC-TOPPS system used to collect this data.)

Table 4.3.a, on the next page, shows that the lives of adolescents (ages 12 to 17) with substance abuse problems who received three months of treatment during CY 2007 improved meaningfully in a variety of areas. Most notably, the percent of youth who used substances decreased by close to two-thirds and those in trouble with the law dropped by almost half. In addition, youth with impaired family relationships decreased by 14 percentage points.



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted January 1, 2007 - December 31, 2007 matched to 3-Month Update Interviews.

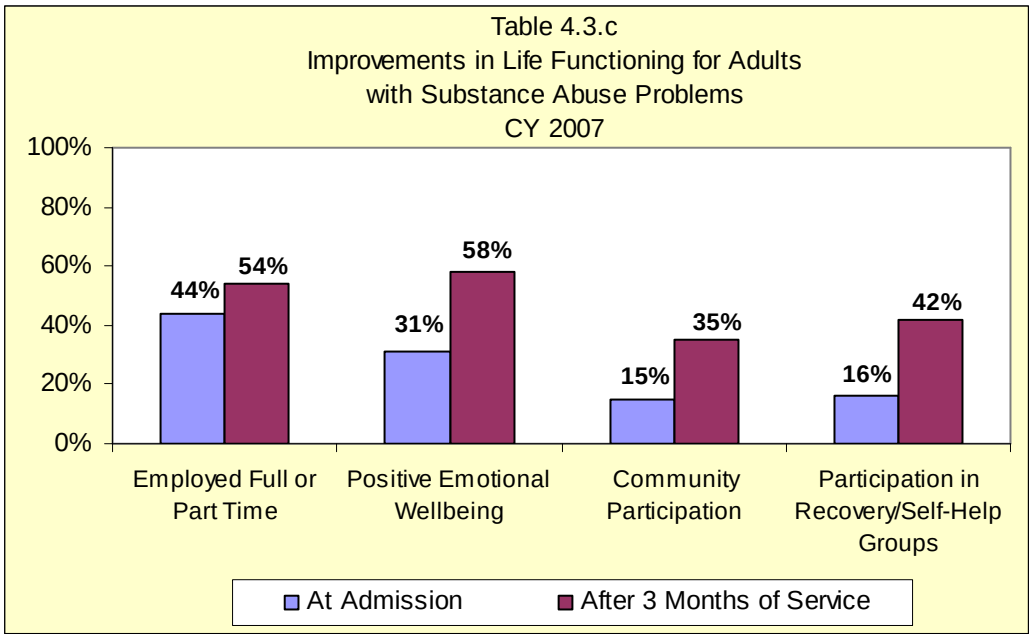
Similar progress was made among adult substance abuse consumers in reducing substance use and related problems as shown in Table 4.3.b. The percent of adults arrested decreased by over three-fourths and the percents using drugs or alcohol dropped by just under three-fourths. In addition, the percent of adults reporting their problems interfere with their work or other daily activities and the percent of consumers having suicidal thoughts was cut in half.



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted January 1, 2007 - December 31, 2007 matched to 3-Month Update Interviews.

Table 4.3.c shows that services also had a positive impact on the quality of life of adult substance abuse consumers.

- The percent of adults employed full or part-time increased by ten percentage points.
- The percent of adults reporting positive emotional wellbeing increased by 27 percentage points.
- The percent of adults participating in positive community activities more than doubled.
- The percent of adults participating in recovery or self-help groups more than doubled.



SOURCE: NC Treatment Outcomes & Program Performance System (NC-TOPPS) Data. Initial Assessments conducted January 1, 2007 - December 31, 2007 matched to 3-Month Update Interviews.

As seen for adult mental health consumers, helping adult substance abuse consumers maintain and improve their employment situation is an area with room for improvement. The Division expects those who remain engaged in services for more than three months to continue improving in this and other areas of their lives.

The Division expects that the state's focus on education and employment opportunities will sustain and improve outcomes in these areas for adults and adolescents who remain engaged in services for more than the three months reported here.

Domain 5: Quality Management Systems

Quality Management refers to a way of thinking and a system of activities that promote the identification and adoption of effective services and management practices. The Division has embraced the CMS Quality Framework for Home and Community-Based Services, which includes four processes that support development of a high-quality service system:

- **Design**, or building into the system the resources and mechanisms to support quality.
- **Discovery**, or adopting technological and other systems to gather information on system performance and effectiveness.

- **Remediation**, or developing procedures to ensure prompt correction of problems and prevention of their recurrence.
- **Improvement**, or analyzing trends over time and patterns across groups to identify practices that can be changed to become more effective or successful.

These processes include activities to ensure a foundation of basic quality and to implement ongoing improvements. The first set of activities, often labeled **quality assurance**, focuses on compliance with rules, regulations and performance standards that protect the health, safety and rights of the individuals served by the public mental health, developmental disabilities and substance abuse services system. The second set of activities, labeled **quality improvement**, focuses on analyzing performance information and putting processes in place to make incremental refinements to the system.

Measure 5.1: Assurance of Basic Service Quality

The Division's State Operated Services (SOS) has been committed to addressing identified problems in the state facilities, including the following quality improvement and compliance-related activities:

- Significant clinical and organizational changes at Broughton Hospital has resulted in regaining CMS certification,
- Comprehensive review of staffing levels and established goals for staffing ratios for nursing and clinical positions; as a result, General Assembly has appropriated 107 additional positions for the state hospitals and additional positions will be requested in subsequent budgets,
- Two clinical nurse specialist positions have been added at each state hospital to provide increased education, monitoring and coaching of nursing staff and,
- Four compliance positions have been added to the SOS (2 for the state hospitals) to increase the ability of the section to participate in mock surveys at the facilities and provide technical assistance related to compliance issues.

On the community side of the system, the LMEs are responsible for monitoring the quality of community service providers. In collaboration with LMEs and providers, the Division has developed and implemented the Frequency and Extent of Monitoring (FEM) tool statewide to assist LMEs in determining how often and in what detail to monitor each individual provider in their catchment area. The tool is designed as a desk review based upon the LME's knowledge of the provider's current performance, using information obtained during endorsement or monitoring reviews and from other sources (such as complaints, incident reports, audits, feedback from other oversight agencies, and analysis of provider performance data). The resulting score, based on several areas of competence, places a provider in one of three levels of "confidence." The tool is first completed following the LME's endorsement review to assess the LME's confidence in the provider's ability to serve consumers safely and effectively. A provider's score is updated when significant changes occur or the provider requests an update.

While the FEM is used to determine the frequency and extent of scheduled monitoring, specific tools have been developed for on-site review of services during an on-site monitoring visit. Those tools are currently being piloted, with an expectation of full implementation in January 2009.

In addition to performing regularly scheduled local monitoring, the LME may choose to conduct supplemental targeted monitoring, if issues or concerns are identified during routine monitoring or through information obtained from other sources. Low scores in particular areas of the FEM may indicate additional areas where a provider may benefit from technical assistance or targeted monitoring.

Because the FEM and on-site monitoring tools are standardized, the data they generate will be available for future analysis of local and statewide strengths and weaknesses in the community service system.

Measure 5.2: Quality Improvement Activities

The *DHHS-LME Performance Contract* requires LMEs to conduct quality improvement projects. The purpose of this requirement is to ensure that each LME includes an ongoing, systematic quality improvement process as an integral part of its planning and policy-making activities. In SFY 2008, LMEs reported on a total of 123 quality improvement projects, with an average of five projects each. For each project the LME is expected to report on:

1) the basis for choosing the issues targeted for improvement (e.g. data analyzed),
2) strategies developed to address identified issues,
3) actions taken,
4) an evaluation of results to date, and
5) recommendations for next steps.

Table 5.2 gives a glimpse of the types of issues that LMEs are addressing in their improvement efforts. Increasing community-based crisis services was the most frequent topic area cited by LMEs, with close to three-fourths of the LMEs submitting a project that focuses on this initiative. Other topics include improving access to services and improving data for local system planning and oversight, as shown in Table 5.2.

Table 5.2
Most Frequent Quality Improvement Initiatives
SFY 2008

Topic	Number of LMEs
Increasing Crisis Services	17
Improving information technology and data management	13
Improving Access to Services	12
Improving consumer outcomes data	10

The Division expects the emphasis on improvement initiatives to help achieve the statewide objectives of the *State Strategic Plan 2007-2010* and to improve performance on critical indicators reported in the *Community Systems Progress Reports*.

Domain 6: System Efficiency and Effectiveness

System Efficiency and Effectiveness refers to the capacity of the service system to use limited funds wisely -- to serve the persons most in need in a way that ensures their safety and dignity while helping them to achieve recovery and independence. An effective service system is built on an efficient management system, key features of which include good planning, sound fiscal management and thorough information management.

The *DHHS-LME Performance Contract* serves as the Division's vehicle for evaluating LME efficiency and effectiveness. As mentioned earlier, the Division has developed a new annual contract to replace the existing three-year contact. It includes a standardized scope of work detailing the components of each function that the LMEs are expected to perform and critical performance indicators for each function. Several of the performance indicators will coincide with measures reported quarterly in the *Community Systems Progress Reports* and included in this report.

Measure 6.1: Business and Information Management

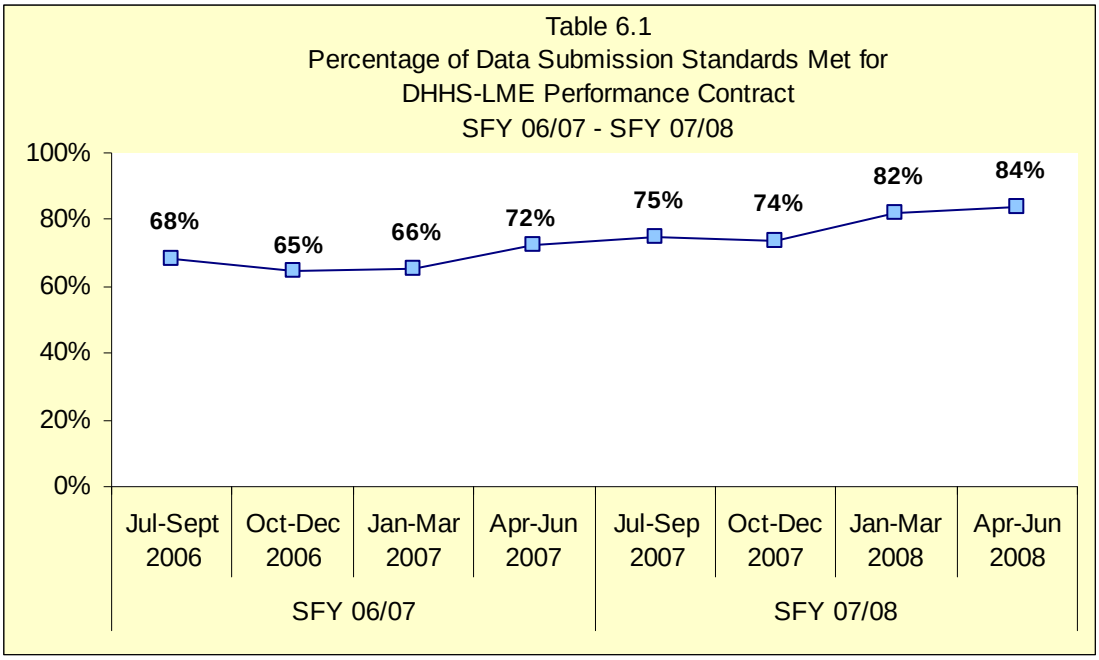
Making good decisions requires the ability to get accurate, useful information quickly, easily and regularly. It also requires efficient management of scarce resources. Staff at all levels need to know the status of their programs and resources in time to take advantage of opportunities, avoid potential problems, make needed refinements and plan ahead.

Consumer data, along with service claims data reported through the Integrated Payment and Reimbursement System, the Medicaid claims system, and the Healthcare Enterprise Accounts Receivable Tracking System, also provide the information that the LMEs and the Division use to evaluate local and state system performance and to keep the Legislature informed of system progress through this report.

For these reasons, compliance is critical to LME and Division efforts to manage the service system. The *DHHS-LME Performance Contract* includes requirements for timely and accurate submission of financial and consumer information. Taken together, the LMEs' compliance with reporting requirements provides an indication of the system's capacity for using information to manage the service system efficiently and effectively.

As shown in Table 6.1, local management entities' submission of timely and accurate information to the Division has improved since the early part of SFY 2006-07. After the drop in the first quarter of SFY 2006-07, performance on data submission has steadily improved over time.

Table 6.1
Percentage of Data Submission Standards Met for
DHHS-LME Performance Contract
SFY 06/07 - SFY 07/08



SOURCE: Data from Quarterly Performance Contract reports.

Since much of the LMEs' data on consumers now comes from private providers, additional training and communication between LMEs and providers is necessary to ensure the timely flow of information. The Division provides ongoing monitoring and technical assistance to LMEs to help ensure the timely and accurate flow of information. The LMEs, in turn, use provider compliance with data reporting requirements, as a factor in determining their provider monitoring decisions. **The Division expects compliance to continue increasing as a result of current training and monitoring efforts.**

Measure 6.2: Efficient Management of Service Funds

As of June 30, 2008 ten out of the twenty-four LMEs had moved to single-stream funding, which provides them with service fund allocations prior to service delivery.[8] Instead of submitting claims to IPRS for reimbursement of services that have been delivered, these LMEs are required to report consumer and service-specific information, called "shadow claims," to IPRS after delivery of those services. Although single-stream funding removes the financial incentive for reporting claims, the *DHHS-LME Performance Contract* requires LMEs with single-stream funding to report at least 85% of the value of their service allocations, primarily through shadow claims. Failure to do so will result in the LME's return to funding based on claims-based reimbursement for services rendered.

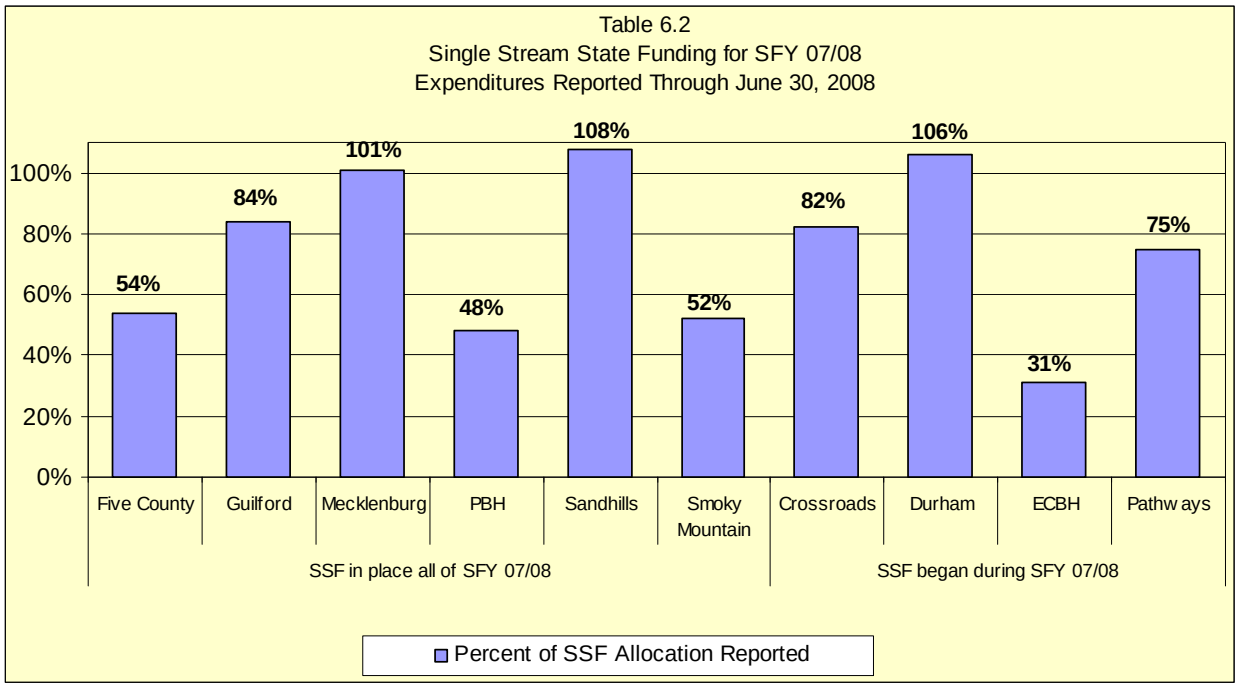
As indicated in Table 6.2, on the next page, only three LMEs have reported the expected volume of services for the fiscal year as shadow claims, each actually exceeding the expected 100% of expenditures reported.[9] Four of the remaining seven LMEs are far behind in reporting services to account for allocated funds.[10]

Three additional LMEs (Western Highlands, CenterPoint, and Southeastern Regional) have been approved to start single-stream funding July 2008. The Division will also monitor their compliance with submission of shadow claims and will be working to ensure that all LMEs with single-stream funding understand the necessity of reporting shadow claims and comply with the requirement in their contract.

[8] As of the date of this report, three additional LMEs have begun receiving single-stream funding.

[9] The Single Stream allocation includes only funds allocated in each LME's single stream account; it excludes Federal funds, MH Trust Funds, LME system management funds, and Medicaid claims processing fees paid by the Division.

[10] Four LMEs (Crossroads, Durham, ECBH, and Pathways) began receiving single-stream funding after SFY 2007-08 had begun. The data in Table 6.2 is pro-rated for these four LMEs based on the date their single-stream status became effective.



SOURCE: Integrated Payment and Reporting System Service Data (for shadow claims submitted by Single-Stream Funded LMEs, July 1, 2007 – June 30, 2008)

The Division expects the quality and completeness of information on the service system in future reports to depend on LMEs' compliance with this requirement.

Domain 7: Prevention and Early Intervention

Prevention and Early Intervention refers to activities designed to minimize the occurrence of mental illness, developmental disabilities, and substance abuse whenever possible and to minimize the severity, duration, and negative impact on persons' lives when a disability cannot be prevented. **Prevention** activities include efforts to educate the general public, specific groups known to be at risk, and individuals who are experiencing early signs of an emerging condition. Prevention education focuses on the nature of mh/dd/sa problems and how to prevent, recognize and address them appropriately. **Early intervention** activities are used to halt the progression or significantly reduce the severity and duration of an emerging condition.

Measure 7.1: North Carolina Strategic Prevention Framework State Incentive Grant

The Strategic Prevention Framework State Incentive Grant (SPF-SIG) is a state-federal cooperative agreement funded by the Substance Abuse Mental Health Services Administration (SAMHSA), Center for Substance Abuse Prevention (CSAP). North Carolina received its SPF-SIG in July 2005, in the second cohort of states funded by CSAP. The national Goals of the SPF-SIG are to:

- Prevent onset and reduce the progression of substance abuse, including underage drinking;
- Reduce substance-related problem in the communities; and
- Build prevention capacities/infrastructure at state and community level.

During the first phase of the project, a statewide needs assessment was conducted. Through the needs assessment and the prioritization process conducted by the grant's State Epidemiological Workgroup, the

statewide priority of reducing alcohol-related traffic crashes and deaths was selected as a focus for grant activities.

A data-driven process identified counties in the state with a) the highest percent of traffic crashes that are alcohol related, b) the highest rates of alcohol-related traffic crashes per 1000 persons, and c) the presence of at least five alcohol-related fatal crashes. The nineteen counties meeting these criteria were invited to apply for SPF-SIG funds. Of these 18 chose to apply and subsequently received funds in collaboration with the Local Management Entities (LME) to conduct the five step Strategic Prevention Framework (SPF) process in their counties.

During the second phase of the project at the community level, Division contractors provided technical assistance and training to assist selected counties and their local partners to conduct an in-depth local needs assessment. A Local Community Advisory Panel (CAP) in each county provides ongoing feedback and input into key decisions. Through these processes, counties have determined sub-communities and local factors that contributed most to alcohol-related crashes. These factors include community norms, issues with law enforcement and adjudication, low perceived risk, and social availability.

In the third phase, the funded communities are receiving technical assistance and training to develop strategies to address identified issues at the local level. Counties are currently in the process of identifying organizations to carry out chosen strategies.

The Division expects this prevention initiative to have a positive impact on the capacity of the state to address substance abuse issues. In addition, the Division expects the SPF model to have a spill-over effect that improves assessment and planning efforts in other areas for the LMEs that are involved in this project.

Conclusion

As shown in the measures reported here, the North Carolina system for mental health, developmental disabilities and substance abuse services continues to make steady progress in many areas, while facing persistent challenges in others. Notable improvements include expansion of evidence-based practices and improved standardization of local provider monitoring processes. Consumer involvement in service decisions and their service outcomes continue to be strong across all age-disability groups, although education and employment outcomes – two of the Division's strategic objectives for the next three years – still have room for improvement.

The two ongoing areas of concern include improving services to individuals with substance abuse problems and reducing the use of state psychiatric hospitals for short-term crisis care that could be better delivered in communities.

The Division has been working closely with the North Carolina Institute of Medicine's Substance Abuse Taskforce to identify ways of improving the identification, engagement, and successful provision of services to individuals with substance abuse problems. Recommendations will be presented to the Legislature in the spring of 2009.

The Division is continuing its efforts to minimize the need for short-term hospitalization by enhancing the availability and coordination of community crisis services and comprehensive services for high-risk consumers. In addition, the Division is working to improve the quality of person-centered plans in identifying processes to prevent and address crises without hospitalization.

Overall, it is clear that system transformation is working, albeit slower than desired, through thoughtful development of a wide array of accessible, evidence-based community services and effective management and oversight of those services.

Appendix A: SAMHSA National Outcome Measures

Substance Abuse and Mental Health Services Administration
National Outcome Measures (NOMs)

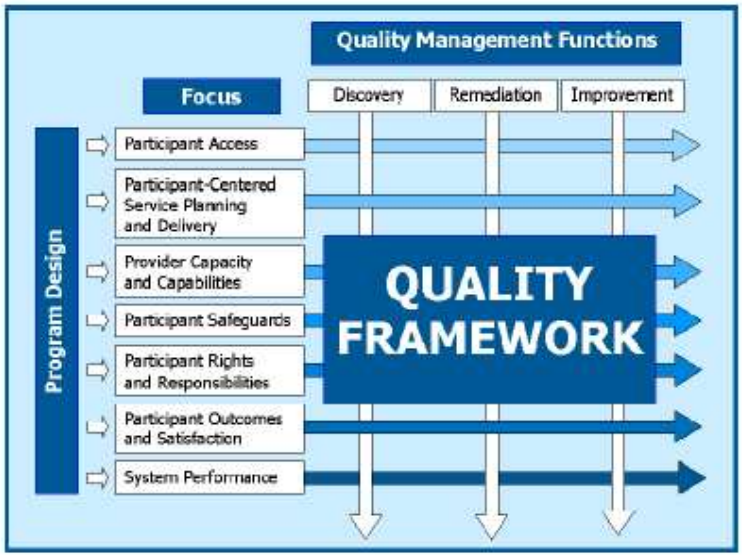
DOMAIN	OUTCOME	MEASURES		
		Mental Health	Substance Abuse	
			Treatment	Prevention
Reduced Morbidity	Abstinence from Drug/Alcohol Use	NOT APPLICABLE	Reduction in/no change in frequency of use at date of last service compared to date of first service ▶	30-day substance use (non-use/reduction in use) ▶ Perceived risk/ harm of use ▶ Age of first use ▶ Perception of disapproval/attitude
	Decreased Mental Illness Symptomatology	Under Development	NOT APPLICABLE	NOT APPLICABLE
Employment/ Education	Increased/Retained Employment or Return to/Stay in School	Profile of adult clients by employment status and of children by increased school attendance ▶	Increase in/no change in number of employed or in school at date of last service compared to first service ▶	Perception of workplace policy; ATOD-related suspensions and expulsions; attendance and enrollment
Crime and Criminal Justice	Decreased Criminal Justice Involvement	Profile of client involvement in criminal and juvenile justice systems	Reduction in/no change in number of arrests in past 30 days from date of first service to date of last service ▶	Alcohol-related car crashes and injuries; alcohol and drug-related crime
Stability in Housing	Increased Stability in Housing	Profile of client's change in living situation (including homeless status) ▶	Increase in/no change in number of clients in stable housing situation from date of first service to date of last service ▶	NOT APPLICABLE
Social Connectedness	Increased Social Supports/Social Connectedness[1]	Under Development	Under Development	Family communication around drug use
Access/Capacity	Increased Access to Services (Service Capacity)	Number of persons served by age, gender, race and ethnicity ▶	Unduplicated count of persons served; penetration rate-numbers served compared to those in need ▶	Number of persons served by age, gender, race and ethnicity
Retention	Increased Retention in Treatment - Substance Abuse	NOT APPLICABLE	Length of stay from date of first service to date of last service ▶ Unduplicated count of persons served ▶	Total number of evidence-based programs and strategies; percentage youth seeing, reading, watching, or listening to a prevention message
	Reduced Utilization of Psychiatric Inpatient Beds - Mental Health	Decreased rate of readmission to State psychiatric hospitals within 30 days and 180 days ▶	NOT APPLICABLE	NOT APPLICABLE
Perception of Care	Client Perception of Care[2]	Clients reporting positively about outcomes ▶	Under Development	NOT APPLICABLE
Cost Effectiveness	Cost Effectiveness (Average Cost)[2]	Number of persons receiving evidence-based services/number of evidence-based practices provided by the State	Number of States providing substance abuse treatment services within approved cost per person bands by the type of treatment	Services provided within cost bands
Use of Evidence-Based Practices	Use of Evidence-Based Practices[2]		Under Development	Total number of evidence-based programs and strategies

[1] For ATR, "Social Support of Recovery" is measured by client participation in voluntary recovery or self-help groups, as well as interaction with family and/or friends supportive of recovery.
[2] Required by 2003 OMB PART Review.

Appendix B: CMS Quality Framework

HCBS QUALITY FRAMEWORK

The Home and Community-Based Services (HCBS) Quality Framework provides a common frame of reference in support of productive dialogue among all parties who have a stake in the quality of community services and supports for older persons and individuals with disabilities. The Framework focuses attention on participant-centered **desired outcomes** along seven dimensions.



Program design sets the stage for achieving these desired outcomes. Program design addresses such topics as service standards, provider qualifications, assessment, service planning, monitoring participant health and welfare, and critical safeguards (e.g., incident reporting and management systems).

Quality management encompasses three functions:

- **Discovery:** Collecting data and direct participant experiences in order to assess the ongoing implementation of the program, identifying strengths and opportunities for improvement.
- **Remediation:** Taking action to remedy specific problems or concerns that arise.
- **Continuous Improvement:** Utilizing data and quality information to engage in actions that lead to continuous improvement in the HCBS program.

Focus	Desired Outcome
Participant Access	*Individuals have access to home and community-based services and supports in their communities.*
Participant-Centered Service Planning and Delivery	*Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community*
Provider Capacity and Capabilities	*There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.*
Participant Safeguards	*Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.*
Participant Rights and Responsibilities	*Participants receive support to exercise their rights and in accepting personal responsibilities.*
Participant Outcomes and Satisfaction	*Participants are satisfied with their services and achieve desired outcomes.*
System Performance	*The system supports participants efficiently and effectively and constantly strives to improve quality.*

Quality management gauges the effectiveness and functionality of program design and pinpoints where attention should be devoted to secure improved outcomes.

Program design features and quality management strategies will vary from program to program, depending on the nature of the program's target population, the program's size and the services that it offers, its relationship to other public programs, and additional factors.

The Framework was developed in partnership with the National Associations of State Directors of Developmental Disabilities Services, State Units on Aging, and State Medicaid Directors.

CMS Centers for Medicare & Medicaid Services · NASDDDS · NASUA · APHSA American Public Human Services Association

Appendix C: Description of Data Sources

Domain 1: Access to Services

Tables 1.1.a – 1.1.c Persons Served: The Division Client Data Warehouse (CDW) provides data on persons served. This system is the primary repository for data on persons receiving public mental health, developmental disabilities, and substance abuse services. It contains consumer demographic and diagnostic information from extracts of the LMEs' management information systems and DHHS service reimbursement systems. It also contains information on consumers' use of state-operated facilities and consumer outcomes extracted from the HEARTS and NC-TOPPS systems described below.

The number of persons served (unduplicated) is calculated by adding the active caseload at the beginning of the fiscal year (July 1) and all admissions during the fiscal year (July 1 through June 30) and subtracting discharges during the fiscal year. The disability of the consumer is based on the diagnosis reported for the consumer on paid IPRS and/or Medicaid service claims. The consumer's age on June 30 at the end of the fiscal year is used to assign the consumer to the appropriate age group (e.g. children or adults).

Table 1.2 Persons Seen within Seven Days of Request: This measure is calculated by dividing the number of persons requesting routine (non-urgent) care into the number who received a service within the next seven days and multiplying the result by 100. The information comes from data submitted by LMEs and published in the *Quarterly DHHS-LME Performance Contract Reports* for SFY 2006-07 and SFY 2007-08. The sources are LME screening, triage, and referral logs and quarterly reports submitted by the LMEs. The data reflect consumers who requested services from an LME. It does not include data on consumers that directly contacted a provider for an appointment. The Division verifies the accuracy of the information through annual on-site sampling of records. More information on the *DHHS-LME Performance Contract*, including the quarterly reports, can be found on the web at: http://www.ncdhhs.gov/mhddsas/performanceagreement/.

Domain 2: Individualized Planning and Supports

Tables 2.1.a and 2.2.a Choice among Persons with Developmental Disabilities: The data presented in these tables are from in-person interviews with North Carolina consumers in the spring of 2006, as part of the National Core Indicators Project (NCIP). This project collects data on the perceptions of individuals with developmental disabilities and their parents and guardians. Approximately 500 in-person interviews with consumers are conducted each year. In addition, over 2,000 mail surveys are sent out each year to parents and guardians of individuals receiving developmental disability services and supports. The interviews and surveys ask questions about service experiences and outcomes of individuals and their families. More information on the NCIP, including reports comparing North Carolina to other participating states on other measures, can be found at: http://www.hsri.org/nci/index.asp?id=reports.

Tables 2.1.b and 2.2.b Choice among Persons with Mental Health and Substance Abuse Disabilities: The SAMHSA-sponsored Mental Health Statistical Improvement Project's Consumer Survey (MHSIP-CS) provides this data. Each LME surveys five percent of its active consumers in the fall of each year. This confidential survey asks questions about the individual's access to services, appropriateness of services, service outcomes, and satisfaction with services. More information on the MHSIP-CS can be found at: http://www.mhsip.org/. Annual reports on North Carolina's survey can be accessed at: http://www.ncdhhs.gov/mhddsas/manuals/.

Domain 3: Promotion of Best Practices

Tables 3.1.a – 3.1.d Providers of Evidence-Based and Best Practices: Information on numbers served in certain services comes from claims data, as reported to Medicaid and the Integrated Payment and Reimbursement System (IPRS).

Tables 3.2.a and 3.2.b Management of State Hospital Usage: The data on the rate of persons served in state psychiatric hospitals by age groups of consumers comes from the North Carolina Community Mental Health Services Block Grant report, which is based on data in the Healthcare Enterprise Accounts Receivable Tracking System (HEARTS), the system used to track consumer care in state-operated facilities. The data on state hospital admissions in SFY 2003-04 through SFY 2007-08 comes from the North Carolina Psychiatric Hospital Annual Statistical Report, which is published by the Division and based on data in HEARTS. This report can be found at: http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm

Table 3.2.c Admissions to ADATC Facilities: The data on admissions to ADATCs in SFY 2003-04 through SFY 2007-08 come from data in the Healthcare Enterprise Accounts Receivable Tracking System (HEARTS), the system used to track consumer care in state-operated facilities. The Division also reports this information in the North Carolina ADATC Annual Statistical Report. This report can be found at: http://www.ncdhhs.gov/mhddsas/statspublications/reports/index.htm

Tables 3.3.a and 3.3.b State Psychiatric Hospital Readmission: The data on state hospital readmissions (30 days and 180 days after discharge) in CY 2007 come from data in the Healthcare Enterprise Accounts Receivable Tracking System (HEARTS), the system used to track consumer care in state-operated facilities.

Table 3.4 Follow-up Care for Consumers Discharged from State Developmental Centers: These data are for SFY 2007-08 and come from reports submitted quarterly by the developmental centers to the Division. The numbers do not include persons discharged from specialty programs (such as programs for persons with both mental retardation and mental illness) or persons who were discharged after receiving respite care only.

Domain 4: Consumer Outcomes

Table 4.1 Outcomes for Persons with Developmental Disabilities: This information comes from NCIP, described in Tables 2.1.a and 2.2.a above.

Tables 4.2.a - 4.3.c Service Outcomes for Individuals with Mental Health and Substance Abuse Disabilities: This information comes from the North Carolina Treatment Outcomes and Program Performance System (NC-TOPPS). This web-based system collects information on a regular schedule through clinician-to-consumer interviews for all persons ages 6 and over who receive mental health and substance abuse services. More information on NC-TOPPS, including annual reports on each age-disability group, can be found at http://nctopps.ncdmh.net/.

Domain 5: Quality Management

Table 5.2 Quality Improvement Activities: The information on LMEs' quality improvement activities comes from annual Quality Improvement reports that the LMEs submitted to the Division in July 2008 as part of their *DHHS-LME Performance Contract* requirements.

Domain 6: Efficiency and Effectiveness

Table 6.1 Business and Information Management: Table 6.1 includes timely, complete and accurate submission of information required in the *DHHS-LME Performance Contract* over the last two years. The composite data submission and reporting performance measure consists of LME submission of consumer data to the CDW, NC-TOPPS, and NC Service Needs Assessment Profile (NC SNAP). It also includes timely submission of reports including use of federal, Substance Abuse Prevention and Treatment Block Grant (SAPTBG) funds, SA/JJ Initiative Reports, and SA Work First Initiative Reports. Data submission requirements have changed during the past two years, due to the discontinuation of some elements and the addition of new elements. In addition, the reporting frequency for SAPTBTG reports varies from quarterly to annually. For these reasons, the number of requirements included in the denominators for Table 6.1 fluctuates between 8 and 11 over the eight fiscal quarters represented. More information on the *DHHS-LME Performance Contract*, including the quarterly reports, can be found at: http://www.ncdhhs.gov/mhddsas/performanceagreement/.

Table 6.2 Percent of Funds Spent: The data for Table 6.2 on shadow claim submissions come from service claims submitted to the IPRS by LMEs with single-stream funding between July 1, 2007 and June 30, 2008. Submitted claims that are reimbursed with federal funds on a unit-cost basis or denied due to lack of funds (a fiscal denial) are included in the numerator, along with federal funds paid on an expense basis. The denominator includes total annual allocations, excluding funds for LME system management and funds received from the Mental Health Trust Fund.

Domain 7: Prevention and Early Intervention

Measure 7.1 North Carolina Strategic Prevention Framework State Incentive Grant: Information on the North Carolina Strategic Prevention Framework State Incentive Grant, including the *State Epidemiological Profile* and the *North Carolina SPF SIG Strategic Plan* can be found at: www.ncspfsig.org.